STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Park Rehabilitation and Healthcare Center	901 Halstead Boulevard Elizabeth City, NC 27909

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff and resident interviews, the facility failed to hold a care plan meeting or invite the resident to participate in the care planning process for 2 of 26 residents whose care plans were reviewed (Resident #26 and Resident #37). The findings included: 1. Resident #26 was admitted to the facility on [DATE]. Resident #26's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had moderate cognitive impairment. Resident #26 was coded for active participation in the assessment and goal setting. Resident #26's care plans were noted as last reviewed or revised on 3/5/2025. Review of Resident #26's electronic medical record revealed no documentation that a care plan meeting was held or that Resident #26 was invited to participate in a care plan meeting during the time between the 12/4/2024 and 3/5/25 care plan meetings. An interview was completed on 5/18/2025 at 2:24 pm with Resident #26. Resident #26 stated she was unable to recall when she last was invited or attended a care plan meeting. Resident #26 stated she would like to have the opportunity to attend her care plan meetings when she felt up to it. An interview was completed on 5/20/2025 at 3:36 pm with the Social Worker. The Social Worker revealed Resident #26's last scheduled care plan meeting was in December 2024. The Social Worker stated Resident #26 declined to attend. The Social Worker stated the next care plan meeting should have been scheduled in March 2025, but she was behind in scheduling care plan meetings and had not scheduled one. The Social Worker stated at the beginning of each month she reviewed the list of residents that had care plans and MDS assessments due for review and scheduled the care plan meetings with residents and their representatives accordingly. An interview was completed on 5/21/2025 at 4:46 pm with the MDS Nurse. The MDS Nurse stated she sent out an email of the upcoming month's MDS assessments that were due for review to the Social Worker so she would know what residents required a care plan meeting to be scheduled. The MDS Nurse stated long-term resident care plan meetings were held quarterly (every 3 months). (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed on 5/21/2025 at 5:03 pm with the Director of Nursing (DON). The DON stated it was the Social Workers' responsibility to schedule care plan meetings and was unsure why the meetings were not being held timely. An interview was completed on 5/21/2025 at 5:17 pm with the Administrator. The Administrator explained the Social Worker had gotten behind with conducting care plan meetings and was currently working to get caught up. 2. Resident #37 was admitted to the facility on [DATE]. Resident #37's most recent quarterly MDS assessment dated [DATE] revealed Resident #37 was cognitively intact. Resident #37 was coded for active participation in the assessment and goal setting. Review of Resident #37's electronic medical record revealed no documentation that a care plan meeting was held or that Resident #37 was invited to participate in a care plan meeting. An interview was completed on 5/19/2025 at 9:24 am with Resident #37. Resident #37 stated she was unable to recall ever having a care plan meeting since her admission to the facility in 2023. An interview was completed on 5/19/2025 at 3:36 pm with the Social Worker. The Social Worker stated Resident #37 attended her scheduled care plan meeting in October 2024. The Social Worker revealed it was her responsibility to schedule and invite residents and their representatives to the care plan meetings. The Social Worker stated she was behind in scheduling care plan meetings for the current year. An interview was completed on 5/21/2025 at 1:37 pm with the DON. The DON stated it was the responsibility of the Social Worker to schedule and invite participants to care plan meetings. The DON stated she was unaware the Social Worker was late in scheduling care plan meetings. An interview was completed on 5/21/2025 at 5:17 pm with the Administrator. The Administrator explained the Social Worker had gotten behind with conducting care plan meetings and was currently working to get caught up.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, the facility failed to provide written information to residents and resident representatives regarding advance directive and/or an opportunity to formulate an advance directive for 19 of 22 residents reviewed for advance directives (Resident #1, #5, #8, #21, #25, #26, #29, #33, #37, #40, #50, #52, #58, #72, #73, #75, #91, #95, and #302). The findings included: a. Review of Resident #1's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness, and hypotension. The review revealed a full code Physician order dated 5/18/25. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive. b. Review of Resident #5's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included heart failure, Alzheimer's disease, and cystitis. The review revealed a full code Physician order dated 10/29/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive. c. Review of Resident #8's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included hypertension, osteoarthritis, and sleep apnea. The review revealed a do not resuscitate Physician order dated 8/6/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive. d. Review of Resident #21's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included hypertension, diabetes, and chronic obstructive pulmonary disease. The review revealed a full code Physician order dated 9/26/22. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive. e. Review of Resident #25's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included hypertension, and chronic pain syndrome. The review revealed a do not resuscitate Physician order dated 4/4/17. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive. f. Review of Resident #26's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included stroke, diabetes, muscle weakness, and high blood pressure. The review revealed a do not resuscitate Physician order dated 11/17/22. There was no documentation in the record for education regarding a formulation of an advance directive and/or the opportunity to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Review of Resident #29's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included diabetes, peripheral vascular disease, and hypertension. The review revealed a do not resuscitate Physician order dated 1/17/22. There was no documentation in the record for education regarding the formulation of an advance directive and/or an opportunity to formulate an advance directive. h. Review of Resident #33's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, epilepsy, and dementia. The review revealed a full code Physician order dated 4/29/25. There was no documentation in the record for education regarding the formulation of an advance directive and/or an opportunity to formulate an advance directive. i. Review of Resident #37's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included heart disease and chronic kidney disease. The review revealed a full code Physician order dated 7/24/24. There was no documentation in the record for education regarding the formulation of an advance directive and/or an opportunity to formulate an advance directive. j. Review of Resident #40's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included heart disease and kidney failure. The review revealed a full code Physician order dated 6/28/24. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive. k. Review of Resident #50's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, diabetes, and atrial fibrillation. The review revealed a full code Physician order dated 10/28/24. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive. l. Review of Resident #52's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included hypertension, kidney disease, and heart failure. The review revealed a do not resuscitate Physician order dated 10/9/24. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive. m. Review of Resident #58's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included end stage renal disease and muscle weakness. The review revealed a full code Physician order dated 5/30/23. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive. n. Review of Resident #72's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included seizure disorder, dementia, and heart failure. The review revealed a full code Physician order dated 11/22/23. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o. Review of Resident #73's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness, and history right hip fracture. The review revealed a full code Physician order dated 4/18/25. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive. p. Review of Resident #75's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included heart disease and kidney failure. The review revealed a full code Physician order dated 3/29/25. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive. q. Review of Resident #91's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included diabetes and congestive heart failure. The review revealed a do not resuscitate Physician order dated 4/4/17. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive. r. Review of Resident #95's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included depression, sleep apnea, and peripheral neuropathy. The review revealed a do not resuscitate Physician order dated 4/29/25. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive. s. Review of Resident #302's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included chronic renal failure. The review revealed a do not resuscitate Physician order dated 5/10/25. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive. An interview was completed on 5/21/25 at 10:47 a.m. with the facility's Admission's Director. The Admission's Director stated she had a blank template for advance directive if someone needed one but that it was not something she discussed with the resident and/or Resident Representative when she completed the admission packet. She stated she reviewed the advance directive from the hospital if the resident had one and verified the code status with the discharge summary. During an interview with the Social Services Director on 5/21/25 at 1:56 p.m. she revealed she had discovered it was her responsibility to provide advance directive education to the resident and/or their Resident Representative a week ago. In an interview with the Administrator on 5/21/25 at 4:25 p.m. he stated the advance directive education was not something identified and had been missed, and he stated the Social Services Director was responsible for ensuring the Advance Directive discussion was completed with the residents and/or Resident Representative on admission and uploaded in the medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review the facility failed to clean and maintain resident rooms for 6 of 29 resident rooms on 1 of 4 halls (300 Hall) observed for environment (Resident #39's room, Resident #29's room, Resident #8's room, Resident #56's room, Resident #92's room, and Resident #25's room). The findings included: The Resident Council meeting minutes dated 7/11/24 revealed there were residents' concerns about housekeeping needing to do a better job cleaning residents' room. The residents reported the housekeeping staff were not sweeping and mopping around or under beds. The Resident Council meeting minutes dated 11/22/24 revealed there were residents' voiced concerns about housekeeping not cleaning residents' rooms or emptying resident trash cans in room. The Resident Council meeting minutes dated 3/21/25 revealed the residents felt the rooms were not being swept or mopped. The residents voiced concern that the floors in their rooms were sticky. The Resident Council meeting minutes dated 4/11/25 revealed the residents voiced concern that the housekeeping staff were not sweeping underneath the furniture. The Resident Council Meeting minutes dated 5/16/25 revealed the residents' voiced concern that room cleaning wasn't being done. 1a. An observation was conducted on 5/18/25 at 12:56 PM of Resident #39's room. The floor by the bed was sticky and there was a strong urine odor present in the room. An interview conducted with Resident #39 on 05/18/25 at 01:12 PM revealed she had concerns about the staff not cleaning the rooms properly. Resident #39 stated the floors were often sticky and housekeeping did not do a good job of sweeping and mopping the floors. b. An observation was conducted on 05/18/25 at 2:47 PM of Resident #29's room. There were marble sized holes in the wall above the base board by the bathroom door and above the baseboard near the bed by the door. An interview conducted with Resident #29 on 05/18/25 at 02:47 PM revealed she had concerns that the rooms were not being cleaned. She stated housekeeping was not cleaning the rooms properly and her room had a strong urine scent in it. She stated housekeeping did not sweep underneath the beds nor around the furniture. She stated housekeeping needed to do a better job. c. An interview conducted with Resident #8 on 05/21/25 08:54 AM revealed she was concerned with urine smell in her room by her bed. Resident #8 stated housekeeping staff did not do a good job cleaning the rooms because they did not sweep underneath the beds and often left food crumbs underneath them. She reported the housekeeping staff barely scrubbed the floors and that was one of the reasons the floors were so sticky and stained. Resident #8 stated she often had to tell the housekeeper to sweep under the bed and clean the floor underneath her bedside commode. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was conducted on 5/21/25 at 8:59 AM of Resident #8's room. The floor in front of the room door in the hall and floor in the room were sticky. There was encrusted brown matter and trash, consisting of hair, dust and bits of paper around the edges of the baseboards. d. An observation was conducted on 5/21/25 at 9:03 AM of Resident # 56's room. There was encrusted brown matter around the edges of baseboard by the door and trash consisting of dust and dirt around the edges of the baseboards. e. An observation was conducted on 5/21/25 at 9:05 AM of Resident # 92's room. There was dark brown matter and trash consisting of dirt, dust and bits of paper in the corners of the room around the edges of baseboards. f. An observation was conducted on 5/21/25 at 9:06 AM of Resident #25's room. There was a broken floor tile by the closet door, dark brown encrusted matter around door, the window frame had missing caulk on the interior side beneath the window exposing an opening about 2 inches in width, to the inside of the wall. There was also damaged drywall paper, the size of a quarter, beneath the bottom of the window. An interview conducted with the Housekeeping Director on 5/21/25 at 10:27 AM revealed she was responsible for ensuring the housekeeping staff maintained the cleanliness of the environment. The Housekeeping Director stated daily cleaning of resident rooms included sweeping, mopping, and cleaning the bathroom. She stated rooms were deep cleaned with all the furniture moved from the wall, cove base cleaned, and the floors swept and mopped. She further stated the rooms were difficult to clean due to the need for replacement of the cove base (a trim that is installed at the base of a wall where it meets the floor) which was stained and had a buildup of wax that had been there for a while. An interview and observation conducted with the Maintenance Director on 5/21/25 at 1:01 PM revealed he was made aware of issues with resident rooms through the facility's online maintenance management system. The Maintenance Director denied being made aware of the broken tile in room [ROOM NUMBER] and exposed area beneath the windowsill. The Maintenance Director stated staff were to enter issues with rooms and equipment in the online system. He further stated the facility used Ambassador Rounds (Management staff assigned to a section of resident rooms to encourage communication with residents and family members) to assist with the cleanliness and reporting of room issues. An interview was conducted with the Administrator on 5/21/25 at 4:58 PM. The Administrator stated the Housekeeping Director was responsible for ensuring the facility is cleaned and Maintenance was responsible for structural repairs. He stated he was made aware by Housekeeping the facility was not accurately using a deep cleaning schedule. The Administrator stated he also expected that Ambassadors would report housekeeping and structural room issues discovered during their rounding each morning during the daily morning meeting for follow up.

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, family and Medical Director interviews, the facility failed to protect a severely cognitively resident from physical restraint from a private duty Caregiver and chemical restraint. When Resident #199 refused to take medications from the Nurse the private duty Caregiver offered to assist and forced medications into the Resident's mouth, held her hand over the Resident's mouth, to force her to swallow. When Resident #199 became combative, and kicking and spitting out medications the private Caregiver restrained the Resident by placing her leg over Resident #199 legs to prevent her from kicking. The Nurse asked the Caregiver to stop and left the room to call the on-call provider. The Caregiver continued to restrain the Resident until the Nurse returned to the room and administered an intramuscular antipsychotic medication (chemical restraint) to calm her. Resident #199 was assessed and a pea size discoloration on the bottom side of her lip was observed. A reasonable person would expect to be safe from physical and chemical restraints in their own home and could experience anger, anxiety, dehumanization, fear and depressed mood. This deficient practice affected 1 of 1 resident reviewed for restraints (Resident #199). The findings included: Resident #199 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, Alzheimer's disease, dementia with behaviors, anxiety disorder and atrial fibrillation. Resident #199's admission Minimum Data Set, dated [DATE] revealed she was severely cognitively impaired with no behaviors. A skin assessment dated [DATE] by the Nurse Practitioner revealed Resident #199 had three visible bruises on the right upper extremity, with the largest on the inner right arm. With no signs of acute trauma noted otherwise. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	In a phone interview on 5/20/25 at 10:53 AM Nurse #2 stated the day of the incident Resident #199 call light rang close to 5:00 PM. Nursing Assistant (NA) #4 answered the call light and reported the Resident needed incontinence care and the private caregiver requested the resident's medications. Nurse #2 indicated she prepared the resident's 5:00 PM Risperdal and entered the room and found Resident #199 sitting on the side of her bed, with her fists balled up, swearing. Nurse #2 reported she explained the medications to the Resident, who refused, when the private caregiver approached the bed and indicated she could get Resident #199 to take her medications. Nurse #2 revealed the Resident refused and tried to swat the medication cup out of the Caregiver's hand when she attempted to give Resident #199 her medications. Nurse #2 indicated she took the medication cup back, and held the Residents hand, trying to calm her, when the Resident laid back across the bed. The Caregiver asked for the medication cup and continued to try to give the resident's her medication, including putting medication into the resident's mouth when Resident #199 would open her mouth to scream, and used a C motion to hold her mouth closed (arm under the chin and hand over the nose to swallow). The Resident tried to spit out the medications and the caregiver put her hand over Resident #199's mouth. Nurse #2 reported that the caregiver laid down beside the Resident on the bed and put her left leg over the Residents legs to prevent her from kicking. Nurse #2 stated she told the Caregiver to stop pushing the medications and she left NA #2 and the Caregiver in the room with the Resident while she went to call the on-call Provider. The Nurse revealed that Nurse #9 was at nurses' station and returned to the room with her, where the Caregiver remained in the same position, lying beside the Resident on the bed with her left leg over the Resident's legs Nurse #2 stated after she cleaned the left outer thigh and administered an IM injection of 2.5 mg of Haldol, the Caregiver released Resident #199 and moved to the side. Nurse #2 revealed she disposed of the needle, returned to sit down beside Resident #199 encouraged her to take deep breaths, to calm down, take a sip of water, and offered incontinence care, which she accepted. Nurse #2 stated the caregiver left the room and she and NA #4 provided Resident #199 her incontinence care. Nurse #2 stated Resident #199 was calm and cooperative with her care. Nurse #2 indicated she left NA #4 with Resident #199 to call the DON and Resident Representative to report the incident. Nurse #2 reported the DON told her the Caregiver was not to touch Resident #199, and the Caregiver had to leave the building. Nurse #2 revealed when she returned to Resident#199 the caregiver was outside the room, was told she had to leave, and the Caregiver left the building. Resident #199's progress notes revealed the following note dated 5/13/25 at 6:30 PM, written by Nurse #2. The resident was observed hitting her private duty caregiver, spitting at staff members, attempting to hit staff members, using extreme profanity towards staff members and her private duty caregiver, attempting to scratch and bite staff members and her private duty caregiver, as well as screaming at staff members and her private duty caregiver. This writer contacted the on-call provider and obtained a verbal order to administer 5mg (milligrams) of IM (intramuscular) Haldol, split into two 2.5mg doses 1 hour apart. This writer administered the first dose now IM into the [outer thigh]. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	In a phone interview on 5/20/25 at 1:41 PM NA #4 indicated she remembered the incident on 5/13/25 as it was the first time she was assigned to Resident #199. She reported the call light was on when she went to check on Resident #199 and the private Caregiver was in the room and requested incontinence care and evening medications. NA # 4 indicated Nurse #2 entered with the medications and she told Nurse #2 to give medications first as she needed to prepare for incontinence care. NA #4 indicated the Resident stated she was not taking the pills and was very aggressive, swearing and saying no to her medications. NA #4 stated the Caregiver indicated to Nurse #2 the Resident would take medications from her and when she (Caregiver) offered, the Resident refused to take the medications from the Caregiver. She reported that the Caregiver placed the pills into Resident #199's mouth and she spit them back out. NA #4 stated the Nurse and Caregiver continued to encourage Resident #199 to take medications when the Caregiver put her knee on the bed beside the Resident and laid her back on the bed. The Resident was kicking her legs, spitting, when the Caregiver laid down beside the Resident and put her leg over the residents' lower legs. Nurse #2 told the Caregiver to stop pushing medications and told me (NA #4) to stay with Resident #199 and she left the room to call the doctor. Nurse #9 returned with Nurse #2 and remained in the room while Nurse #2 gave the Resident an injection in her upper leg. NA #4 reported she left the 2 nurses in the room and saw the Caregiver leave the hall while she was passing out meal trays. NA #4 reported that Nurse #2 never restrained Resident #199, she held her hand and tried to soothe her. In an interview on 5/20/25 at 12:16 PM the Director of Nursing (DON) revealed she was aware of the incident with Resident #199 and the private Caregiver. She stated she received a call from Nurse #2 on 8/13/25 who reported Resident #199 was refusing her medications and the private Caregiver indicated she could get the Resident to accept her medications. Nurse # 2 explained she handed Resident #199's medications to the Caregiver, and the Resident refused the Caregiver. The Caregiver laid down on the bed beside the Resident and put her leg over Resident #199 to keep her from kicking out. At that point Nurse #2 told the Caregiver to Stop and she took the medication cup back from the Caregiver. Nurse #2 left NA #4 in the room with the Resident and went to call the on-call Provider for orders. The DON reported this was reported to her that once the caregiver was removed from the room Resident #199 began to calm down and allowed staff to provide her with incontinence care. The DON revealed Resident #199 was admitted from the hospital with bruising to her arms, and the skin assessment she conducted on 5/13/25 revealed Resident #199 had a new small bruise to lower lip and denied any pain. The DON reported she told Nurse #2 to make sure the Caregiver left the facility, and she was on her way to the facility to assess Resident #199 and interview staff. A skin assessment dated [DATE] at 5:30 PM completed by the Director of Nursing (DON) indicated that Resident #199 had bruising to the right-hand purple in color, bruising to right arm, and resident had a very small bruise to lower lip on right side green/purple in color, resident denies pain to any of these areas. The assessment was completed by the Director of Nursing (DON). Review of Medical Director's Progress Note dated 5/14/25 at revealed Resident #199 was an [AGE] year-old female patient with a past medical history of atrial fibrillation, hypertension, hyperlipidemia, hypothyroidism, and progressing dementia. The Patient does have multiple bruises to bilateral upper extremities and a new small purple area to the underside of her bottom lip on the right side. Patient does not appear to have had any decline with physical functioning since admission here. Range of motion appears to be appropriate with no changes. She is completely awake and alert with no increase in lethargy or sedation noted. No tearfulness or increased depression noted. The patient appears to be at her normal baseline today with no changes. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/21/25 at 1:05 PM the Medical Director stated he was notified of the incident between Resident #199 and private Caregiver on 5/13/25. He revealed he assessed the Resident on 5/14/25 and found she had no memory of the incident, no bruising and no complaint of pain and was smiling. In an interview on 5/21/25 at 4:45 PM the Administrator stated he was notified by Nurse #2 on 5/13/25 at 7:03 PM of the incident with Resident #199 and her private Caregiver. He stated the Resident was refusing her medications and shut her mouth tight when Nurse #2 offered medications. The Caregiver told Nurse #2 it would be easier for her to take medications from her and asked Nurse #2 to let her give the medications. The Caregiver took the medications, when Resident #199 opened her mouth, the Caregiver dumped the medications in her mouth and put her hand over Residents #199 mouth. The Resident refused, trying to kick and bite the staff, when the Caregiver laid the resident back on the bed and lay beside her. As Resident #199 continued to kick out at staff the Caregiver placed her leg over the Resident's leg to stop her from kicking. At this time Nurse #2 stepped in and told the Caregiver to stop and she tried to calm the resident down. Nurse #2 left NA #4 with the Resident and left to call the on-call Provider who gave an order for Haldol IM (intramuscular). The Administrator stated they determined the private Caregiver's behavior was inappropriate and she was banned from the facility. The Administrator stated they notified the State Agency and Law Enforcement of the incident on 5/13/25 and the staff members involved were sent home pending the facility's investigation.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	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** Based on record review, and staff and Resident Representative interviews, the facility failed to notify the resident, Resident Representative and Ombudsman in writing of the reason for transfer/discharge to the hospital and failed to fully complete the bed hold policy document when a resident transferred to the hospital. The deficient practice affected 3 of 3 residents reviewed for hospitalization (Resident #72, Resident #21, Resident #52). The following included: 1. Resident #72 was admitted to the facility on [DATE]. A review of Resident #72's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. A review of Resident #72's nursing progress notes revealed she was discharged to the hospital on 4/30/25 and returned on 5/15/25. a. A review of the bed hold policy dated 4/30/25 revealed Resident #72's Resident Representative had signed the document. Further review of the bed hold policy revealed there were no dates of hospitalization completed and bed hold accept, or decline had not been marked. An interview conducted with the Business Office Manager (BOM) on 05/21/25 at 10:50 AM revealed the bed hold form was prefilled with the dollar amount to hold a bed. The BOM stated she was not responsible for doing anything with the bed hold policy unless the resident or Resident Representative wanted to hold the bed. The BOM stated then she would talk to the Resident Representative about payment. The BOM further stated nursing sent the form with the resident automatically when they went to the hospital. The BOM stated she believed Admissions was supposed to follow up with the resident or Resident Representative to see if they wanted to pay for the bed hold. b. Review of the April 2025 transfer/discharge list revealed no documentation had been sent to the Ombudsman for residents who transferred to the hospital in the month of April. An interview conducted with the Social Worker on 05/20/25 at 12:10 PM revealed she fell behind and had not sent the discharge/transfer list to the Ombudsman for any April discharges yet. The Social Worker stated she normally sent the transfer/discharge list the first week of each month. c. Further review of Resident #72's medical record did not reveal documentation that a written transfer/discharge notice was provided to the resident or Resident Representative when Resident #72 transferred to the hospital on 4/30/25. An interview conducted with Resident #72's Resident Representative on 05/21/25 at 3:30 PM revealed he did not receive a written notice but was told by phone when Resident #72 went to the hospital. An interview conducted with the admission Coordinator on 5/20/25 at 3:38 PM revealed she was not responsible for sending out a written notice of transfer/discharge. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview conducted with the Social Worker on 5/20/25 at 3:40 PM revealed she was not aware that she needed to send a written notice of transfer/discharge to the resident or Resident Representative when a resident was transferred to the hospital. An interview conducted with the Administrator on 5/21/25 at 4:55 PM revealed he expected that a follow up phone call would be made to the Resident Representative to discuss the bed hold policy and follow up documentation. The Administrator further stated he expected that written notification of transfer/ discharge would be provided to the resident and Resident Representative for residents transferred to the hospital and documentation sent to the Ombudsman. 2. Resident #21 was admitted to the facility on [DATE]. A review of Resident #21's quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of a nurse's note dated 9/17/24 revealed Resident #21was sent out to the emergency department for evaluation and the Resident Representative was notified. A review of Resident #21's nursing progress notes revealed she was discharged to the hospital on 9/18/24 and returned on 9/26/24. Further review of Resident #21's medical record did not reveal documentation that a written transfer/discharge notice was provided to the resident and Resident Representative when Resident #21 transferred to the hospital on 9/17/24. An interview conducted with the admission Coordinator on 5/20/25 at 3:38 PM revealed she was not responsible for sending out written notices of transfer/discharge. An interview conducted with the Social Worker on 5/20/25 at 3:40 PM revealed she was not aware that she needed to send a written notice of transfer/discharge to the resident or Resident Representative when transferred to the hospital. An interview conducted with the Administrator on 5/21/25 at 4:55 PM revealed he expected that written notification of transfer/ discharge would be sent to the resident and Resident Representative for residents transferred to the hospital. 3. Resident #52 was admitted to the facility on [DATE]. A review of Resident #52's quarterly MDS assessment dated [DATE] revealed the resident had moderate cognitive impairment. A review of Resident #52's nursing progress notes revealed she was discharged to the hospital on 8/9/24 and returned on 8/12/24. Further review of Resident #52's medical record did not reveal documentation that a written transfer/discharge notice was provided to the resident and Resident Representative when Resident #52 transferred to the hospital on 8/9/24. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview conducted with the admission Coordinator on 5/20/25 at 3:38 PM revealed she was not responsible for sending out written notices of transfer/discharge. An interview conducted with the Social Worker on 5/20/25 at 3:40 PM revealed she was not aware that she needed to send a written notice of transfer/discharge to the resident and Resident Representative when transferred to the hospital. An interview conducted with the Administrator on 5/21/25 at 4:55 PM revealed he expected that written notification of transfer/ discharge would be sent to the resident and Resident Representative for residents transferred to the hospital.

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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 observation, record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of smoking and elopement alarms for 1 of 26 residents whose MDS assessments were reviewed (Resident #33). The findings included: Resident #33 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbances and bipolar disorder. Review of the Safe Smoking Screening assessment dated [DATE] revealed Resident #33 was assessed and determined to require supervision while smoking. The assessment further noted the care plan was updated to reflect Resident #33's smoking status. Resident #33 had a physician order dated 4/29/25 for wander guard (elopement alarm) device, check placement every shift. The nursing progress note dated 4/29/25 at 3:32 pm revealed Resident #33 had a wander guard placed on the right ankle. The care plan initiated on 4/29/25 revealed Resident #33 had a care plan in place for smoking with an intervention which included supervision while smoking. The care plan further revealed Resident #33 was an elopement risk related to dementia with an intervention for wander guard as ordered. Review of the MDS admission assessment dated [DATE] revealed Resident #33 had moderate cognitive impairment and used a wheelchair for mobility. Resident #33 was not coded for tobacco use and was not coded for use of the wander/elopement alarm. An observation and interview were conducted on 5/18/25 at 1:59 pm with Resident #33 who was observed in bed with a wander guard in place. Resident #33 reported he was a smoker at the facility. An interview was conducted on 5/21/25 at 3:08 pm with the MDS Nurse who revealed she did not see Resident #33's wander guard and did not see the order so she did not code the resident for use of a wander guard on the assessment. The MDS Nurse further noted that she was aware of Resident #33's smoking status and had entered a care plan for smoking but just missed the area of tobacco use when she coded the MDS assessment. During an interview on 5/21/25 at 4:23 pm with the Administrator he revealed the MDS Nurse was responsible to ensure Resident #33's assessment was coded correctly.

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, resident and Responsible Party (RP) interviews, the facility failed to provide the resident or the RP a written summary of the baseline care plan and medication list for 2 of 4 residents reviewed for care planning (Resident #75 and Resident #91). The findings included: 1. Resident #75 was admitted to the facility on [DATE]. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #75 had severe cognitive impairment. Resident 75's electronic health record revealed no documentation that Resident #75 or his RP received a written summary of the baseline care plan and medications. During an interview on 5/18/25 at 12:23 pm with Resident #75's RP she revealed was at the facility almost every day and she had not been given any information regarding the plan of care or medications for Resident #75. An interview was conducted with the Social Worker on 5/20/25 at 12:04 pm who revealed she was responsible to provide a written summary of the care plan and medication list to the resident and/or their RP. The Social Worker stated she attempted to have the baseline care plan and medication list given to Resident #75 and his RP within 72 hours of admission but she had fallen behind with the process. An interview was conducted on 5/21/25 at 3:41 pm with the Director of Nursing (DON), who revealed the Social Worker was responsible to provide residents and/or their RP with a written summary of the baseline care plan and medication list. The DON stated she was not aware the Social Worker had not provided the information to Resident #75's RP regarding the baseline care plan and medications. During an interview on 5/21/25 at 4:24 pm the Administrator stated that the Social Worker was responsible to ensure the baseline care plan process was completed as required, but he stated the Social Worker just fell off track. 2. Resident #91 was admitted to the facility on [DATE]. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #91 was cognitively intact. Review of the electronic health record revealed no documentation that Resident #91 received a written summary of his baseline care plan and medications. During an interview on 5/18/25 at 2:38 pm, Resident #91 revealed he had not received any documentation about his plan of care or medications since he was admitted to the facility. (continued on next page)

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview was conducted with the Social Worker on 5/20/25 at 12:04 pm who revealed she was responsible to provide a written summary of the care plan and medication list to Resident #91. The Social Worker stated she attempted to have the baseline care plan and medication list given to Resident #91 within 72 hours of admission but she had fallen behind in the process. An interview was conducted on 5/21/25 at 3:41 pm with the Director of Nursing (DON), who revealed the Social Worker was responsible to provide Resident #91 with a written summary of the baseline care plan and medication list. The DON stated she was not aware the Social Worker had not provided the information to Resident #91 regarding the baseline care plan and medications. During an interview on 5/21/25 at 4:24 pm the Administrator stated that the Social Worker was responsible to ensure the baseline care plan process was completed as required, but he stated the Social Worker just fell off track.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to update the care plan to include hearing aids for 1 of 33 residents whose care plans were reviewed (Resident #29). The findings included: Resident #29 was admitted to the facility on [DATE]. Review of the medical record revealed Resident #29 was seen by audiology for evaluation and treatment on 9/12/24. A physician's order dated 2/5/25 indicated the hearing aids were to be inserted every morning. A physician's order dated 2/6/25 indicated the hearing aids were to be removed at bedtime. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 had moderate cognitive impairment. The resident was coded as having adequate hearing and wore hearing aids. The care plan, updated 3/19/25, did not include a focus area related to hearing loss or the wearing of new hearing aids. An observation of Resident #29 on 05/19/25 at 9:19 AM revealed the resident was not wearing her hearing aids. An interview with Resident #29 on 5/19/25 at 9:20 AM revealed she did have hearing aids, but she did not like wearing them. She stated the hearing aids felt strange in her ears. An interview conducted with Nurse #9 on 5/19/25 at 9:25 AM revealed Resident #29 had just started wearing hearing aids about a month ago and frequently refused to wear them. An interview conducted with the MDS Nurse on 5/21/25 at 4:45 PM revealed she missed the assessment and did not add the hearing aids to the care plan. The MDS nurse stated updates to resident assessments were discussed in the daily morning meeting. An interview conducted with the Director of Nursing on 5/21/25 at 4:50 PM revealed Resident #29 should have had a care plan to reflect she wore hearing aids. The DON stated care plans were reviewed daily during morning clinical meeting. An interview conducted with the Administrator on 5/21/25 at 4:55 PM revealed he expected care plans to be reviewed during morning clinical meeting and updated to reflect the resident's status.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident, staff, and physician interviews, the facility failed to obtain a physician order for the use and care of an indwelling urinary catheter for 1 of 2 residents reviewed for urinary catheter (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of the bladder (a condition where the nerves and muscles that control urination were not working properly causing urinary retention) and a history of a spinal fracture. Resident #1's care plan last revised on 4/30/25 revealed he had an indwelling urinary catheter due to neuromuscular dysfunction of the bladder with interventions which included positioning the catheter bag and tubing below the level of the bladder and away from entrance room door. The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact and was coded for the use of an indwelling urinary catheter. A hospital Discharge summary dated [DATE] revealed Resident #1 had an indwelling urinary catheter in place during his hospital stay and at the time of discharge. Record review of the Physician's orders revealed no order for Resident #1's indwelling urinary catheter or for the care of the indwelling urinary catheter. An observation on 5/18/25 at 2:49 pm revealed Resident #1 was in bed with the indwelling urinary catheter drainage bag hung from the lower rail on the Resident's bed and below the level of the bladder. An interview was completed on 5/18/25 at 2:55 pm with Resident #1. The Resident stated he has had the indwelling urinary catheter for many years. Resident #1 stated the facility's nursing staff cared for the indwelling urinary catheter on all shifts. An interview was completed on 5/21/25 at 10:55 am with Nurse #6. The Nurse stated she readmitted Resident #1 to the facility on 5/15/25 during her 3:00 pm to 11:00 pm shift. Nurse #6 verified Resident #1 was readmitted to the facility with an indwelling urinary catheter. Nurse #6 stated she reviewed the hospital discharge summary sent with Resident #1 and entered the medications listed on it. Nurse #6 stated she reviewed the medications with the Physician and the oncoming 11:00 pm to 7:00 am nurse. Nurse #6 indicated she did not know how to reactivate the discontinued orders for the indwelling urinary catheter and the care of it and believed the oncoming 11:00 pm to 7:00 am nurse was going to reactivate the indwelling urinary catheter orders. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed on 5/21/25 at 11:54 am with Nurse #1. The Nurse stated she reviewed Resident #1's discharge medications with Nurse #6 on 5/15/25 for correct dosages and amounts. Nurse #1 stated it was Nurse #6's responsibility to reactivate/enter the orders for the indwelling urinary catheter and the care of it. Nurse #1 stated she was unaware Nurse #6 did not know how to reactivate discontinued orders. An interview was completed on 5/21/25 at 12:35 pm with the Medical Director. He revealed an indwelling urinary catheter required a Physician order. The Medical Director stated the order for Resident #1's indwelling urinary catheter should have been entered upon readmission. An interview was completed on 5/21/25 at 5:09 pm with the Director of Nursing (DON). The DON revealed a Physician order was required for Resident #1's indwelling urinary catheter. The DON was unable to state why the order was not entered or reactivated when Resident #1 was readmitted with the indwelling urinary catheter. The DON stated new admissions and readmissions were reviewed during the facility's daily clinical morning meeting. The DON stated Resident #1's omitted indwelling urinary catheter Physician order was an oversite during the clinical morning meeting. An interview was completed on 5/21/25 at 5:13 pm with the Administrator. The Administrator stated nursing was required to ensure that Physician orders were in place to properly care for Resident #1's indwelling urinary catheter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident, Pharmacist and Medical Director interviews, the facility failed to have effective systems in place to ensure intravenous (a soft, flexible tube placed inside a vein used to give medicine or fluids) antibiotic medication was available as ordered for a newly admitted resident for 1 of 2 residents reviewed for IV antibiotic therapy (Resident #95). The findings included: Review of the hospital Discharge summary dated [DATE] revealed Resident #95 had an order to administer cefazolin (antibiotic) solution 2 grams intravenous (IV) every 8 hours for 42 days. Resident #95 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis (bone infection) of the left ankle and foot. The Admission/readmission assessment dated [DATE] at 8:52 pm completed by Nurse #3 revealed Resident #95 had a bone infection of the left lower extremity and had IV access in the left arm. Resident #95 had a physician order dated 4/29/25 for cefazolin solution injection 2 grams; administer 2 grams intravenously every 8 hours for bone infection for 42 days. The medication was scheduled to be administered at 6:00 am, 2:00 pm, and 10:00 pm. Review of the Medication Administration Record (MAR) for April 2025 revealed the following: 4/29/25 at 10:00 pm the cefazolin administration was noted as 9 by Nurse #3. Further review of the MAR revealed 9 was identified as other see nurse note. The MAR administration note dated 4/29/25 at 9:46 pm by Nurse #3 revealed the cefazolin was on order. 4/30/25 at 6:00 am the cefazolin administration had no administration documentation noted on the MAR by Nurse #1. No further documentation was noted in the medical record. 4/30/25 at 2:00 pm the cefazolin administration was noted as 9 by Nurse #4. The MAR administration note dated 4/29/25 at 2:18 pm by Nurse #4 revealed the cefazolin was awaiting from pharmacy. 4/30/25 at 10:00 pm the cefazolin administration was noted as 9 by Nurse #2. The MAR administration note dated 4/29/25 at 10:44 pm by Nurse #2 revealed the cefazolin medication schedule was updated. The nursing progress note dated 4/30/25 at 9:40 pm by Nurse #2 revealed she contacted the pharmacy regarding Resident #95's cefazolin. Nurse #2 further noted the pharmacy stated Resident #95's cefazolin was not sent in the earlier delivery but it would be sent to the facility on the next run and should arrive around midnight. Nurse #2 informed the pharmacy that Resident #95 needed his medication as soon as possible and that it was a delay in care. Review of the emergency dose kit (a kit that provided certain medications for residents until available from pharmacy) medication list revealed IV cefazolin was not available in the emergency dose kit. (continued on next page)

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	345184	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Park Rehabilitation and Healthcare Center	901 Halstead Boulevard Elizabeth City, NC 27909

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #95 was cognitively intact and was coded for the use of antibiotic medication and had intravenous access. During an interview on 5/18/25 at 12:39 pm Resident #95 revealed he was worried about his bone infection because he missed several doses of his IV antibiotic when he was admitted to the facility. He stated he was not sure why he didn't get the IV antibiotic for the first few days of his admission, but he stated he told a nurse (unsure of the name) that he needed to have his antibiotic as it was ordered. A telephone interview was conducted on 5/21/25 at 11:32 am with Nurse #3 who was assigned to Resident #95 at the time of the admission. Nurse #3 stated Resident #95 arrived at the facility later in the evening on 4/29/25 and she confirmed the admission medication orders at that time. Nurse #3 stated normally the resident medications would be delivered to the facility the next day when the resident arrived late in the evening. Nurse #3 stated she was not sure what time the pharmacy delivered medications to the facility but she did not have the cefazolin to administer to Resident #95 on 4/29/25 at 10:00 pm. An interview was conducted with Nurse #1 who was assigned to Resident #95 on 4/30/25 for 6:00 am dose of cefazolin. Nurse #1 stated Resident #95's cefazolin was not available at the facility so she contacted the pharmacy and she was told it would be out for delivery to the facility later in the day. Nurse #1 stated the pharmacy normally made a delivery to the facility between 1:00 am and 3:00 am but the medication was not in the delivery so she was unable to administer it to Resident #95 on 4/30/25 at 6:00 am. During an interview on 5/20/25 at 2:28 pm with Nurse #4 she revealed the pharmacy normally would deliver IV antibiotics on the same night the resident was admitted but she stated at times it would take several days to receive IV antibiotics. Nurse #4 stated she did not call the pharmacy to check on the delivery date or time for Resident #95's IV cefazolin 2:00 pm dose on 4/30/25 because he was just admitted the night before and she expected it to be delivered later that day. A telephone interview was conducted with Nurse #2 on 5/20/25 at 11:16 am who revealed when she returned to work on 4/30/25 and saw that the IV cefazolin had not yet been received at the facility and that Resident #95 had missed several doses she contacted the Director of Nursing (DON) and the Pharmacy. Nurse #2 reported that when she called the pharmacy they were unable to tell her why the IV cefazolin was not sent out to the facility but she was told the antibiotic was on the evening delivery and would be available for the 10:00 pm dose on 4/30/25. Nurse #2 stated when the IV medication was still not available for the 10:00 pm dose she called the pharmacy back and told the Pharmacist that Resident #95's care had been delayed due to not having the IV antibiotics as ordered and they stated it would be delivered the next day. Nurse #2 stated she notified the provider and changed the medication administration schedule to start on 5/01/25 when the next expected shipment from pharmacy arrived to ensure all 42 doses would be administered. An interview was conducted with the admission Director on 5/20/25 at 8:46 am who revealed the facility was notified of Resident #95's admission date of 4/29/25 and that the IV cefazolin was needed. The admission Director stated the facility should have been able to obtain Resident #95's IV antibiotic medication when he was admitted . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on 5/20/25 at 3:26 pm with the Pharmacist who revealed the cut-off time for intravenous antibiotics to be sent out for new admissions on the evening delivery was 5:30 pm. He stated if a resident admitted after that time the IV medication would be sent on the first delivery of the next day. The Pharmacist stated Resident #95's cefazolin should have been sent to the facility on the first delivery run on 4/30/25. He stated the delay in the delivery of Resident #95's cefazolin could have been due to an issue with the pharmacy medication log (used to track lot numbers and expiration dates of medications sent to facilities) being incorrectly completed by pharmacy staff or being shorthanded at the pharmacy on 4/30/25. The Pharmacist stated one or both of those reasons could have contributed to the delay of Resident #95's IV cefazolin being available for administration. An interview was conducted on 5/21/25 at 12:53 pm with the Medical Director, who was assigned as the medical provider for Resident #95 at the facility, revealed when medication was not available at the facility for a resident the nurse should contact the pharmacy and the pharmacy would have to be able to provide information about when to expect the medication. The Medical Director stated there should be a better system in place between the pharmacy and the facility to ensure all newly admitted resident medications were available to be administered as ordered. The DON was interviewed on 5/21/25 at 2:29 pm. She revealed the facility had some difficulty obtaining medications timely from the pharmacy for new admissions. The DON stated that when new admissions arrive at the facility the orders were confirmed by the nurse assigned to the resident and that would send the orders to the pharmacy. The DON stated the new admission medications were normally delivered on the same day of admission except for the residents that admitted later in the evening and most often would arrive the next day. She stated the facility had an emergency dose kit which had many common medications that could be used for new admissions until their specific medications arrived at the facility. The DON stated she was not aware if the IV cefazolin was a medication that was available in the emergency dose kit. An interview was conducted on 5/21/25 at 3:01 pm with the Administrator who revealed he was not aware of any issues regarding IV medications from the pharmacy not being delivered timely for new admissions. The Administrator stated the DON was responsible to ensure that Resident #95's IV cefazolin was available and administered as ordered.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, and Physician interviews, the facility failed to administer scheduled intravenous (a soft, flexible tube placed inside a vein used to give medicine or fluids) antibiotic medication which resulted in 4 doses of the antibiotic being missed for 1 of 2 residents reviewed for IV antibiotic therapy (Resident #95). The findings included: Resident #95 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis (bone infection) of the left ankle and foot. Resident #95 had a physician order dated 4/29/25 for cefazolin (antibiotic) solution injection 2 grams; administer 2 grams intravenously every 8 hours for bone infection for 42 days. The medication was scheduled to be administered at 6:00 am, 2:00 pm, and 10:00 pm. Review of the Medication Administration Record (MAR) for April 2025 revealed the Resident #95's cefazolin was not administered on the following dates: 4/29/25 at 10:00 pm noted as on order by Nurse #3. 4/30/25 at 6:00 am noted as not administered, no further documentation by Nurse #1. 4/30/25 at 2:00 pm noted as awaiting from pharmacy by Nurse #4. 4/30/25 at 10:00 pm noted as not administered and medication schedule updated by Nurse #2. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #95 was cognitively intact and was coded for the use of antibiotic medication and had intravenous access. During an interview on 5/18/25 at 12:39 pm Resident #95 revealed he missed several doses of his antibiotic when he was admitted to the facility. A telephone interview was conducted on 5/21/25 at 11:32 am with Nurse #3 who was assigned to Resident #95 at the time of the admission on [DATE]. Nurse #3 stated she did not have the cefazolin to administer to Resident #95 on 4/29/25 at 10:00 pm since he was a new admission and the pharmacy had not yet delivered the medication. An interview was conducted on 5/21/25 at 11:48 am with Nurse #1 who was assigned to Resident #95 on 4/30/25 for the 6:00 am dose of cefazolin. Nurse #1 revealed Resident #95's cefazolin was not delivered to the facility by the pharmacy so she was unable to administer the medication to Resident #95. Nurse #1 stated she contacted the pharmacy and was advised that the medication would arrive later in the day. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 2:28 pm with Nurse #4 who was assigned to Resident #95 on 4/30/25 and documented the 2:00 pm noted as awaiting from pharmacy. Nurse #4 revealed the cefazolin was not yet delivered to the facility and she was not able to administer the antibiotic to Resident #95. Nurse #4 stated the facility had a backup box (medication dispensing machine) but she did not think cefazolin was one of the medications that was available. She stated she did not call the pharmacy to check on the delivery because Resident #95 was just admitted the night before and she expected it to be delivered later that day. A telephone interview was conducted with Nurse #2 on 5/20/25 at 11:16 am who was assigned to Resident #95 on 4/30/25 for the 10:00 pm dose of cefazolin. Nurse #2 reported that Resident #95's cefazolin was not available for administration on 4/30/25 at 10:00 pm. She stated she called the pharmacy and was notified that Resident #95's cefazolin would be delivered the next day. Nurse #2 stated she notified the provider and changed the medication administration schedule to start on 5/01/25 when the next expected shipment from pharmacy arrived to ensure all 42 doses of the cefazolin would be administered to Resident #95. An interview was conducted on 5/21/25 at 12:53 pm with the Physician who revealed he was made aware of the medication not being available for Resident #95 and that the cefazolin order was adjusted. He stated he did not feel the missed doses of cefazolin harmed Resident #95 in the grand scheme of his care and treatment. The Physician stated as long as the order was adjusted to ensure the total number of the prescribed doses were in place, he did not feel the missed doses were detrimental to Resident #95's care. The Physician stated there should be a better system in place between the pharmacy and the facility to ensure all newly admitted resident medications were available to be administered as ordered. The DON was interviewed on 5/21/25 at 2:29 pm. The DON revealed that new admission orders were not able to be activated until the resident arrived at the facility and once activated the orders were submitted to the pharmacy to be reviewed and delivered. The DON stated the new admission medications were normally delivered on the same day of admission except for the residents that admitted later in the evening. She stated for those residents that admitted late in the evening there could be a delay until the next day for some of the prescribed medications. The DON stated she was aware of the missed doses of Resident #95's cefazolin and that the order was updated to add the missed doses. An interview was conducted on 5/21/25 at 3:01 pm with the Administrator who revealed the DON was responsible to ensure that Resident #95's IV cefazolin was available to be administered as ordered.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on staff interview and review of the Facility Assessment the facility failed to identify any cultural considerations for the resident population, failed to ensure the staffing plan considered specific staffing needs for each unit and shift as required, and failed to evaluate contracted services utilized by the facility to provide necessary care for its residents during normal operations and emergencies which had the potential to affect 88 of 88 residents. The findings included: Review of the Facility Assessment revealed it was revised on 3/12/25. The Facility Assessment did not include any cultural considerations to meet the needs of the residents of the facility. Further review of the Facility Assessment revealed that the staffing plan listed the number of Nurses (Registered Nurse or Licensed Practical Nurse) and Certified Nursing Assistants (CNAs) noted as the desired number FTE (full-time equivalent, the total number of full-time employees working in an organization) of staff and the professional requirement for those staff members. However, the staffing plan did not address staffing needs for each shift and weekends, or address staffing needs in these areas based on changes to the resident population as required. The Facility Assessment did not note if a contract or other agreement was in place related to the provider who was responsible for the provision of goods, medical services, facility management services, emergency services, transportation, and dialysis services for the facility. An interview was conducted with the Administrator on 5/21/25 at 4:12 pm who revealed he thought he had completed the cultural consideration portion of the facility assessment but must have missed it. He reported he was not aware of the requirement to specifically address the nurse staff shift information and emergency staffing plan any further than the FTE information. The Administrator stated he was not aware the contracted services used at the facility had to be included in the Facility Assessment.