STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345195	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgecombe Health Center by Harborview	1000 Western Boulevard Tarboro, NC 27886

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 0711 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, the Physician and Nurse Practitioner (NP), the facility failed to ensure that Nurse Practitioner visits were comprehensive and included a review of the Medication Administration Records (MARs). On [DATE], an emergency room (ED) physician prescribed Lasix (furosemide) 20 milligrams (mg), (diuretic/water pill) daily for 3 days and Prednisone 20 mg, 3 tablets daily for 5 days for dyspnea (shortness of breath), Chronic Obstructive Pulmonary Disease exacerbation (long term lung conditions that cause irreversible damage to the airway), and fluid overload (retention of water and sodium). On [DATE], a nurse entered the Prednisone order into the electronic record but did not activate a 5-day stop date. As a result, the medication remained active and continued to be administered until [DATE]. On [DATE], the NP completed a follow-up visit after the ED encounter and acknowledged the Prednisone and Lasix orders but did not verify the medication administration record. The NP conducted subsequent visits on [DATE] and [DATE] but again did not review the medication administration record. A review of the medication administration record during either visit would have revealed the ongoing Prednisone administration. On [DATE], Resident # 162 developed cold-like symptoms including wheezing, sneezing, nasal congestion, lethargy, and decreased appetite and was treated with Macrobid (antibiotic) for a urinary tract infection. On [DATE] the resident's family requested a hospital transfer due cough, cold symptoms, and non-productive cough. Resident # 162 was admitted to the hospital on [DATE] with a diagnosis of systemic inflammatory response syndrome (SIRS). Resident # 162 did not respond to treatment and expired on [DATE] at 1:33 AM. This deficient practice affected 1 of 8 residents reviewed for Nurse Practitioner review of the Resident's total care, including medications and treatments (Resident # 162). Immediate jeopardy began on [DATE], when the Nurse Practitioner failed to review the medication administration records during the routine visit. The Immediate Jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Resident # 162 was admitted on [DATE] with diagnosis including vascular dementia, chronic congestive heart failure (CHF) (the heart muscle is to weak or stiff to pump blood efficiently), coronary artery disease (CAD) (major blood vessels supplying the heart becomes narrowed or blocked by plaque, restricting the flow of blood to the heart muscle), atherosclerotic heart disease (ASHD) (fatty, cholesterol-rich deposits build up inside the arteries that supply blood to your heart), diabetes mellitus, hypothyroidism (thyroid gland does not produce enough essential hormones), hyperlipidemia, valvular heart disease (conditions affecting the heart and its connected network of blood vessels), chronic obstructive pulmonary disease (COPD) (progressive long term lung conditions that cause irreversible damage to the airway), atrial fibrillation (irregular heartbeat), pulmonary hypertension (small blood vessels in the lungs become narrowed, blocked or destroyed, forcing the heart to work harder), lymphedema (abnormal persistent swelling caused of protein by a build-up rich lymph fluid in the body's soft tissues), (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hypertension, cerebral vascular accident (CVA or stroke), and viral pneumonia was diagnosed [DATE]. Resident # 162's nursing progress note written by Nurse # 10 dated [DATE] at 6:48 PM revealed Resident # 162 stated she doesn't feel well and she stated she could not breathe. Vital signs T 97.7 (normal 96.4 to 98.5 Fahrenheit), P 93 (normal 60 to 100), R 18 (normal 20 to 30), BP 124/78 (normal 90/60 to 120/80) and Oxygen saturation (O2 Sat) 97% on 2 liters per minute oxygen (normal is 88-92 for COPD resident). Family at bedside requested Resident # 162 be transferred to the hospital.Review of Hospital After Care Summary dated [DATE] documented Resident # 162 was treated for shortness of breath, dyspnea, COPD exacerbation and fluid overload. The emergency room physician prescribed Prednisone 20 mg, 3 tablets by mouth with breakfast for 5 days; lasix 20mg by mouth each morning for 3 days; and continue oxygen at 2 liters per minute via nasal cannula. Review of nursing progress notes dated [DATE] at 11:34 PM revealed Resident # 162 returned to the facility. Review of the Physician orders entry dated [DATE] at 5:02 AM identified Nurse # 1 transcribed the Prednisone order as Prednisone 20 mg, 3 tablets by mouth with breakfast for 5 days, starting [DATE]; lasix 20 mg, 1 tablet every morning for 3 days; and oxygen at 2 liter per minute via nasal cannula continuously. However, the nurse did not activate a 5-day stop date for Prednisone, allowing the medication to remain active indefinitely. The lasix order was correctly entered for 3 days starting [DATE].Review of the Nurse Practitioner (NP) progress notes dated [DATE] documented a follow-up after the ED visit. The NP observations included Resident # 162 was lying in bed with oxygen on, no obvious distress, no cyanosis (bluish or purple discoloration of the skin) or accessory muscles (neck and chest muscles used to help with breathing). The NP documented the plan to continue: Prednisone 60 mg daily for 5 days and Lasix 20 mg daily for 3 days. The NP also documented reviewing and updating medications, allergies, problem list, and medical, surgical, social and family histories. Record review of Resident #162's Medication Administration Record (MAR) revealed Prednisone 20 mg, 3 tablets by mouth one time a day for COPD, to be taken with breakfast for 5 days starting [DATE]. The Prednisone was documented as administered daily from [DATE] through [DATE] which included the original 5 doses [DATE] through [DATE] then 8 additional unnecessary doses. Review of the NP progress notes dated [DATE] documented a routine visit for medical management of chronic illness. The NP indicated that previous labs and charting were reviewed and that diagnosis were stable. The NP documented reviewing and updating Resident # 162's allergies, medications, problem list, and past medical, surgical, social and family histories as appropriate. However, the NP did not identify that Prednisone 20 mg, 3 tablets daily, continued to be administered. There was no documentation showing review of the medication administration record, and the ongoing error remained uncorrected. Review of Resident # 162's medication administration record revealed Lasix 20mg, one tablet administered on [DATE], [DATE] and [DATE]. Review of Resident # 162's medication administration record revealed that Prednisone 20 mg, 3 tablets daily, ordered for 5 days beginning on [DATE], continued to be administered every day from [DATE] through [DATE], totaling 25 additional doses beyond the already-exceeded 5-day duration. Review of Resident # 162's Nurse Practitioner progress note dated [DATE], the NP completed a follow-up visit on [DATE] related to a change of condition reported the evening before. At the time of the call, staff reported Resident # 162's vital signs included heart rate was 117, blood pressure 89/61, lungs clear bilaterally, no difficulty breathing on oxygen 2 liters/minutes via nasal cannula, and oxygen saturation 94%. Despite conducting the follow-up evaluation, the NP did not review the medication administration record, and the ongoing Prednisone administration remained unidentified. An in-person interview conducted with the Nurse Practitioner on [DATE] at 11:30 AM revealed during his routine visit on [DATE] and follow up note on [DATE], he did not mention the Prednisone in his notes as this was not one of the disease processes he was looking at during that time frame. He stated during his routine visits he reviews the medication administration records, however between November of 2025 through February 2026 there was a glitch in the system. The NP stated his iPad would not open multiple screens, so he was unable to access the MARs. The NP stated the Nurses would have opened the MARs if he had asked them (continued on next page)

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F 0711 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	too, however he did not request a nurse to open the MARs to review the current medications being administered to Resident # 162 during his routine or follow-up visits with Resident # 162. He did not report the alleged system issue to the Administrator or the Physician. A review of Resident # 162's medication administration record (MAR) showed Prednisone 20 mg, 3 tablets (60 mg) was administered daily from [DATE] through [DATE]. This includes 5 appropriate doses from [DATE] through [DATE] and 61 additional unnecessary doses from [DATE] through [DATE]. The error remained uncorrected because the initial order did not include a stop date, and Nurse Practitioner visits did not include medication administration record review. Review of the Situation Background Assessment Recommendations written by Nurse # 22 dated [DATE] at 7:12 PM revealed Resident # 162 complained of cold like symptoms (cough, cold and congestion, and a non-productive cough). Nurse # 22 assessed the resident, and family member present requested that Resident # 62 be sent to the ED. Vital signs included blood pressure 124/82, temperature 97.2, pulse 65, respirations 18, blood sugar 118, oxygen saturation 96% on oxygen at 2 liters per minute via nasal cannula. Resident # 162 was sent to the ED per family request. Nurse # 22 was not available for an interview. Resident # 162's ED Physician documentation included resident was examined and presented to the ED with respiratory distress and suspected COPD versus CHF. The ED critical care attestation written by the ED physician on [DATE] stated Resident # 162 had a high probability of life-threatening deterioration in conditions, at the initial presentation or during the ED course due to respiratory failure. Resident # 162 was transferred from the ED and admitted to the medical intensive unit (MIU) for sepsis. Review of Resident # 162's Certificate of Death, with date of death of [DATE] at 1:33 AM, identified the final disease or condition resulting in death as cardiac arrest with pulseless electrical activity, severe sepsis with multi-system organ failure and Respiratory Syncytial Virus. An interview conducted with the Physician on [DATE] at 10:47 AM revealed that steroids given for any length of time can cause bone loss, adrenal issues (adrenal glands make hormones that help keep your metabolism, blood pressure, immune system and stress response in balance) and euphoria and require gradual weaning. The physician reviewed the emergency room notes from [DATE] and stated Resident # 162 had an infection, respiratory distress, and an inflammatory reaction to Respiratory Syncytial Virus. The physician stated Prednisone could have reduced the resident's ability to fight infection and that long-term steroids decrease the immune response and could have contributed to her demise. He stated during routine visits, Physicians and Nurse Practitioners are expected to review allergies, active medications, problem list, and medical, surgical, social and family histories and updated them as appropriate. During a telephone interview on [DATE] at 3:03 PM, the previous Director of Nursing (DON # 2) reported the Nurse Practitioner never informed her that the medication administration system had a glitch preventing medication administration access. The NP had previously asked her to open the medication administration records for other residents when needed, but he did not request assistance opening the medication administration records for Resident # 162 in November or [DATE]. No issues or glitches in the electronic medication system were reported during the time frame the Nurse Practitioner described. The Administrator was notified of the immediate jeopardy on [DATE] at 4:05 PM. The facility provided the following credible allegation of immediate jeopardy removal. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.Resident #162 was admitted to the facility on [DATE] with multiple diagnoses, including COPD, CHF, CAD, diabetes mellitus, atrial fibrillation, vascular dementia, and other chronic conditions.On [DATE], following an Emergency Department visit, Resident #162 was prescribed Prednisone 20 mg, three tablets (60 mg total) by mouth daily with breakfast for five days for COPD. The order was entered into the electronical health record by the nurse and included the prednisone was to be given for 5 days but the nurse did not activate the 5-day duration within the order. As a result, the medication remained active on the Medication Administration Record and Resident #162 continued to receive Prednisone 60 mg daily until [DATE]. Due to the extended administration of the prednisone beyond the intended duration, the resident was at risk for adverse (continued on next page)

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F 0711 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	effects associated with prolonged steroid therapy.The Nurse Practitioner conducted routine visits on [DATE] and [DATE]; however, the ongoing Prednisone order was not identified, reviewed, or addressed during those visits. The Nurse Practitioner later reported that a system issue occurred from [DATE] through February 2026 and prevented access to the Medication Administration Records (MARs) for all residents limiting the ability to review active medications during that period. The Nurse Practitioner failed to report this to Administration, and there were no reported glitches within the electronic administration record system during this time.On [DATE], the [NAME] President of Operations completed an audit to ensure all medical providers had appropriate access to the electronic health record system which includes the MARs. The audit revealed no additional concerns related to provider access.Beginning on [DATE] the Nurse Practitioner will review all physician orders and MARs for all current residents from [DATE] through February 2026 to determine if any other residents were affected by the deficient practice or any changes need to be made to their current medical regimen. To be completed by [DATE].Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.On [DATE], the [NAME] President of Operations and Administrator conducted a Root Cause Analysis regarding Resident #162's prolonged prednisone therapy. During an interview [DATE] the Nurse Practitioner admitted to the Administrator and [NAME] President of Operations that he did not check the residents' MARs when completing routine visits from [DATE] through February 2026 due to not being able to simultaneously pull up multiple tabs on his iPad. There was no glitch with the Electronic Medical Record (Point Click Care) from [DATE] through February 2026. The NP indicated he didn't think to communicate it with anyone at the facility or the Medical Director. The Administrator then instructed the Nurse Practitioner to utilize an alternate electronic device if he was to have issues with his iPad in the future.On [DATE], the Administrator began educating by phone/in person all the medical providers including the Medical Director, Physician Assistants and Nurse Practitioners regarding the expectation that Medication Administration Records (MARs) be reviewed during routine resident visits and they will be informed of and educated on the entire regulation: F711. They were instructed to immediately notify the Administrator if they experience any difficulty accessing resident records, including Medication Administration Records, so that corrective action can be taken without delay. They were also instructed that effective immediately, providers will meet with the Director of Nursing or designee at the conclusion of each facility visit to review any medication concerns and verify that medication orders are complete and compliant with facility protocols. Completed by [DATE]. Any newly contracted primary providers will receive education from the Staff Development Coordinator regarding electronic health record access procedures and to report any issues with access to the resident records to the Administrator before providing services within the facility. The facility alleges removal of the immediate jeopardy and compliance on [DATE].Validation of the immediate jeopardy removal plan was conducted on [DATE]. The [NAME] President of Operations completed an audit of the electronic health record system to ensure all medical providers had access to the electronic health records of residents. The Nurse Practitioner reviewed all physicians' orders and medication administration records for all current residents. The [NAME] President of Operations completed a root cause analysis regarding the prolonged prednisone therapy. The Administrator provided education to the Medical Director and Nurse Practitioner regarding Medication Administration Reviews being completed during routing visits. Interviews with medical providers revealed they attended in-services and participated in audits as outlined in the corrective action plan. The immediate jeopardy removal and compliance date of [DATE] was validated.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety 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, Pharmacy Consultant, Pharmacy Quality Assurance Manager, and Physician interviews, the facility failed to have effective systems in place for accurate acquiring of medications and the pharmacy failed to have effective systems in place to prevent refilling a medication order 3 times after the stop date. On [DATE] Resident #162 was seen in the emergency department (ED) for shortness of breath, dyspnea, COPD exacerbation and fluid overload and returned to the facility just before midnight. The ED Physician prescribed Prednisone 20 mg (milligrams) 3 tablets (total of 60 mg daily) at breakfast for 5 days for diagnosis of dyspnea (shortness of breath or difficulty, uncomfortable breathing), chronic obstructive pulmonary disease exacerbation (long term lung diseases that cause inflammation and damage to airways, making it difficult to breathe). Prednisone is a corticosteroid used to reduce inflammation and suppress an overactive immune system, treating a wide range of conditions including respiratory diseases. On [DATE] a Nurse transcribed the order into the electronic medical record for Prednisone 20 mg give 3 tablets at breakfast for 5 days; however, the Nurse did not enter a stop date for the order. This order was transmitted directly to the pharmacy electronically and the pharmacy and the pharmacy also did not enter the 5-day stop date when the order was reviewed. The pharmacy delivered Prednisone 20 mg, 15 tablets on [DATE]. Facility nursing staff ordered 3 refills for the Prednisone without a physician order, and the pharmacy filled and delivered 15 tablets on [DATE], 90 tablets on [DATE], and 90 tablets on [DATE] all after the 5-day stop date. Prednisone 20 mg, 3 tablets (60 mg) were administered to Resident # 162 daily from [DATE] through [DATE], totaling 66 days of administration, 61 days past the medication stop date. Possible negative outcomes of receiving 60 mg of Prednisone longer than 5 days may include hyperglycemia (high blood sugar), psychotic disturbance (loss of contact with reality), fluid retention (excess fluid buildup in the body's tissues), decreased ability to fight infection, and a decrease in inflammatory mediators (small molecules and proteins that coordinate the body's immune response to injury or infection). On [DATE] the resident's family requested a transfer to the hospital due to complaints of cough, cold and congestion with non-productive cough. Emergency Department (ED) vital signs included oxygen saturation 79% on room air (normal range for oxygen saturation for someone with COPD is 88% to 92%) and the resident was immediately placed on BiPAP (bilevel positive non-invasive ventilation). Active hospital problems included SIRS (systemic inflammatory response syndrome- a life-threatening medical condition characterized by a widespread inflammatory response throughout the body triggered by infection), RSV (acute bronchiolitis due to respiratory syncytial virus), hypoxia, and sepsis (life-threatening reaction to an infection that causes your immune system to harm healthy tissues and organs). Resident #162 was transferred to the medical intensive unit for sepsis and did not respond to treatment and expired on [DATE] at 1:33 AM. This deficient practice affected 1 of 8 residents reviewed for providing pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) (Resident # 162).Immediate jeopardy began on [DATE] when the pharmacy did not enter the 5-day stop date for Resident #162's Prednisone order when the order was reviewed by a pharmacist. Immediate Jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included:1. Review of the facility's Pharmacy Services policy implemented [DATE] and reviewed/revised [DATE] indicated it was the policy of this facility to ensure that pharmacy services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	practice. Pharmaceutical Services refers to: the process of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering, monitoring responses to, using and disposing of all medications, biologics, and chemical. Compliance Guidelines included: the facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing and administration of all routine medications and emergency drug and biologics to meet the needs of the residents. Resident # 162 was admitted on [DATE] with diagnosis including vascular dementia, chronic congestive heart failure (CHF) (the heart muscle is to weak or stiff to pump blood efficiently), coronary artery disease (CAD) (major blood vessels supplying the heart becomes narrowed or blocked by plaque, restricting the flow of blood to the heart muscle), atherosclerotic heart disease (ASHD) (fatty, cholesterol-rich deposits build up inside the arteries that supply blood to your heart), diabetes mellitus, hypothyroidism (thyroid gland does not produce enough essential hormones), hyperlipidemia, valvular heart disease (conditions affecting the heart and its connected network of blood vessels), chronic obstructive pulmonary disease (COPD) (progressive long term lung conditions that cause irreversible damage to the airway), atrial fibrillation (irregular heartbeat), pulmonary hypertension (small blood vessels in the lungs become narrowed, blocked or destroyed, forcing the heart to work harder), lymphedema (abnormal persistent swelling caused of protein by a build-up rich lymph fluid in the body's soft tissues), hypertension, cerebral vascular accident (CVA or stroke), and viral pneumonia was diagnosed [DATE].Review of Resident # 162's nursing progress note written by Nurse # 10 dated [DATE] at 6:48 PM revealed Resident # 162 stated she doesn't feel well and stated she could not breathe. Family was at bedside and wanted the resident sent out to the hospital. Resident # 162 was sent to the hospital emergency department (ED). Review of Hospital After Care Summary dated [DATE] revealed Resident # 162 was treated for shortness of breath, dyspnea, COPD exacerbation and fluid overload. The emergency department physician prescribed Prednisone 20 mg, 3 tablets by mouth with breakfast for 5 days, and 20mg by mouth in the morning for 3 days. Review of nursing progress notes dated [DATE] at 11:34 PM revealed Resident # 162 returned to the facility. Review of the Physician orders dated [DATE] at 5:02 AM identified Nurse # 1 transcribed an order for Resident # 162 in the electronic medical record physician order system for Prednisone give 3 tablets by mouth one time a day for COPD take 3 tablets by mouth with breakfast for 5 days/ER Provider, start date [DATE] and end date indefinite and this order was transmitted directly to the pharmacy electronically. Record review of the pharmacy medication delivery sheets revealed: Prednisone 20mg, 15 tablets were delivered on [DATE]. Further review of the pharmacy medication delivery sheets revealed the facility continued to request refills and the facility received:Prednisone 20mg, 15 tablets were delivered on [DATE].Prednisone 20mg, 90 tablets were delivered on [DATE].Prednisone 20mg, 90 tablets were delivered on [DATE]. Review of Resident #162's Medication Administration Records (MARs) from [DATE] through [DATE] revealed the Prednisone order appeared on the MARs as follows: Prednisone oral tablet 20 mg give 3 tablets by mouth one time a day for COPD take 3 tablets by mouth with breakfast for 5 days, Start Date [DATE] at 8:00 AM. The Prednisone was documented as administered daily from [DATE] through [DATE]. The MAR revealed 5 doses administered from [DATE] through [DATE], and an additional 61 doses administered from [DATE] through [DATE]. The resident received a total of 66 doses of Prednisone 60 mg. Review of the SBAR written by Nurse # 22 dated [DATE] at 7:12 PM revealed Resident # 162 complained of cold like symptoms (cough, cold and congestion, and a non-productive cough). Nurse # 22 assessed the resident, and family member present requested that Resident # 62 be sent to the emergency department (ED). Resident # 162 was sent to the ED per family request. Review of the emergency medical services (EMS) patient care record dated [DATE] indicated the call was received from the facility at 6:42 PM and EMS personnel was dispatched at 6:44 PM. EMS was at the bedside at 6:50 PM and observed Resident # 162 lying in a fetal position in bed with a cough present. A family member at the bedside stated the facility was treating Resident # 162 for a urinary tract infection and the flu. At 6:58 PM the resident (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was alert and pulse was 80, respirations 30, oxygen saturation was 70%, and BP was unable to be obtained. At 7:03 PM the resident was alert and her pulse was 124, respirations were 28, oxygen saturation was 84%, and BP was unable to be obtained. The EMS assessment of Resident # 162 included altered mental status, decreased breath sounds, and lower leg swelling 2+ pedal edema (fluid accumulation causing swelling in the feet and ankles). EMS left the facility at 7:12 PM to transport Resident # 162 to the ED. During transportation to the ED, Resident # 162 oxygen saturation remained in the 70's and EMS increased the resident's oxygen to 4 liters per minute. EMS was unable to obtain a blood pressure and the resident had no radial (inside of wrist) pulse. Resident # 162's respirations became labored, and lung sounds decreased. EMS placed the resident on CPAP (continuous positive airway pressure- breathing therapy device that delivers air to a mask worn over the nose and mouth to help consistent breathing), obtained IV access, and started intravenous fluids. Resident continued to decline, and the level of consciousness became altered. EMS removed the CPAP and assisted ventilations with a bag-valve mask (also known as an Ambu bag, is a manual resuscitation method used to deliver oxygen to patients with apnea or severe respiratory failure until advanced airway management can be performed). Upon arrival to the emergency room, EMS gave report and transferred care to the receiving hospital.Review of hospital emergency department (ED) notes dated [DATE] at 7:36 PM revealed Resident #162 was transported by the emergency medical services (EMS) and presented with hypoxia (low levels of oxygen in your body tissues which can cause symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin). The resident was immediately placed on BiPAP (bilevel positive non-invasive ventilation). Physical exam noted leg edema, wheezing and rales without obvious respiratory distress. Musculoskeletal assessment revealed 3 + pitting edema, palpable pulses only at the neck, and cool skin. The ED Physician documented respiratory distress and suspected COPD versus CHF. Active hospital problems included SIRS (systemic inflammatory response syndrome- (a life threatening medical condition characterized by a widespread inflammatory response throughout the body triggered by infection), RSV (acute bronchiolitis due to respiratory syncytial virus), hypoxia, sepsis, elevated liver function tests, cystitis (inflammation of the bladder), lactic acidosis (a serious condition that can disrupt normal physiological functions and requires prompt medical attention), acute respiratory failure, leukocytosis (elevated white blood cell count) , elevated troponin level (elevated levels of troponin are a strong indicator of heart attack), acute kidney injury (sudden decline in kidney function occurring within hours or days), and hyperkalemia (higher than normal levels of potassium in the blood levels may cause life threatening heart arrythmias). ED critical care attestation on [DATE] stated the resident had a high probability of life-threatening deterioration in conditions, at the initial presentation or during the emergency department course due to respiratory failure. Resident # 162 was transferred from the ED and admitted to the medical intensive unit (MIU) for sepsis. Review of Resident # 162's Certificate of Death, with date of death of [DATE] at 1:33 AM, identified the final disease or condition resulting in death as cardiac arrest with pulseless electrical activity, severe sepsis with multi-system organ failure and Respiratory Syncytial Virus. A telephone interview conducted on [DATE] at 9:56 AM with the Pharmacy Consultant revealed the pharmacy should have initiated an automatic stop date when the order was received for Prednisone 20 mg, 3 tabs for five days, and the Pharmacy Consultant was unable to comment on the pharmacy's procedure for this process. A telephone interview conducted on [DATE] at 11:59 AM with the Pharmacy Quality Assurance Manager revealed the pharmacy should have dispensed only 15 tablets of Prednisone for the ordered regimen of Prednisone 20, mg 3 tablets daily for 5 days for Resident # 162. The Pharmacy Quality Assurance Manager stated the pharmacy processed two 15 tablet orders and two 90-day supply orders but should have processed only 15 tablets for the 5-day order. He explained medication orders go through an order entry process in which certain fields, including the stop date, must be manually entered even though the order itself auto-populates. He stated the pharmacist verifies the order, ensures the medication, drug, and dose match, and then populates the quantity and supply date according to the order's (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	directions while also checking clinical appropriateness, before dispensing the medication. He further stated that when the Prednisone order for Resident # 162 was received, a stop date should have been added based on the duration of therapy. The order entry processor should have entered the stop date, and the Pharmacist should have identified the missing stop date during clinical appropriateness review and added it. A telephone interview conducted with the previous Director of Nursing (DON) # 2 on [DATE] at 3:03 PM revealed she served as DON # 2 from [DATE] through [DATE]. DON # 2 stated she was not aware that Prednisone 20 mg, 3 tablets daily for 5 days continued to be administered beyond the ordered 5 days for Resident # 162. DON #2 did not offer an explanation for why the nurses continued to order and administer the medication. She stated that when nurses enter new, updated, or discontinued orders in the electronic medical record physician order system, the system automatically updates the electronic medication administration record (MAR). She reported nurses do not review MARs month- to- month to ensure accuracy. She stated the nurse must select an end date using the system calendar or enter the number of days the medication is to be given so the system can calculate the stop date. If neither was entered, the medication would continue to flag for administration. She stated the nursing leadership team (DON # 2 and unit managers) reviewed new, changed, and discontinued orders the next day for accuracy. However, she could not confirm whether Resident # 162's new orders dated [DATE] were reviewed, noting the order must have been missed since it continued without stopping. An interview conducted on [DATE] at 10:47 AM with the Physician revealed steroids given for any length of time can result in loss of bone, adrenal issues and euphoria, and residents must be weaned off Prednisone. The Physician reviewed the emergency room notes from [DATE] and stated Resident # 162 had an infection, respiratory distress, and an inflammatory reaction to the Respiratory Syncytial Virus. The Physician stated Prednisone could have decreased Residents # 162's potential to fight infection and long-term steroids decrease the immune response and could have contributed to her demise. He stated the Prednisone order should have been followed as written by the emergency room Physicians; Prednisone 20 mg, 3 tablets for five days. A telephone interview conducted with the Pharmacy Quality Assurance Manager on [DATE] at 3:34 PM revealed there is no manufacturer defined maximum dose of Prednisone; however, the typical dose for someone with COPD is 30 to 40 mg for 5 days. He stated that depending on the resident's comorbidities, 60 mg may have been an appropriate dose but only for 5 days and only for a severe COPD exacerbation - not indefinitely. He stated possible negative outcomes of receiving 60 mg of Prednisone longer than 5 days may include hyperglycemia (high blood sugar), psychotic disturbance (loss of contact with reality), fluid retention (excess fluid buildup in the body's tissues), decreased ability to fight infection, and a decrease in inflammatory mediators (small molecules and proteins that coordinate the body's immune response to injury or infection). He reiterated that 60 mg should not have been administered beyond the 5-day regimen. The Administrator was notified of the immediate jeopardy on [DATE] at 4:05 PM. The facility provided the following immediate jeopardy removal plan with a compliance date of [DATE].Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.Resident #162 was admitted to the facility on [DATE] with diagnoses including vascular dementia, CHF, CAD, CVA, diabetes mellitus, valvular heart disease, COPD, atrial fibrillation, pulmonary hypertension, bipolar disorder, and hypertension.On [DATE], following an Emergency Department visit, Resident #162 was prescribed Prednisone 20 mg, three tablets (60 mg total) by mouth daily with breakfast for five days for COPD. The order was entered into the electronical health record by the nurse and included the prednisone was to be given for 5 days but the nurse did not activate the 5-day duration within the order. As a result, the medication remained active on the Medication Administration Record and Resident #162 continued to receive Prednisone 60 mg daily until [DATE]. Due to the extended administration of the prednisone beyond the intended duration, the resident was at risk for adverse effects associated with prolonged steroid therapy. In addition, nursing staff continued to reorder the medication after the 5-day stop date and the pharmacy continued to send refills for the prednisone when requested by the (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility without a physician order. On [DATE] the Administrator interviewed the Pharmacy Quality Assurance Manager who stated that when the prescription for prednisone for Resident #162 was received by the pharmacy, a stop date should have been added to the order at that time based on the prescribed duration of therapy. The failure to add a stop date allowed the order to remain active in the pharmacy system and continued to be refilled and dispensed to the facility.An audit of reorders on [DATE] completed by the pharmacy revealed the same nurse reordered the medication 3 times, each time it was refilled in error.On [DATE] at 2:38 PM the facility Chief Clinical Officer indicated in an email that a pharmacy representative stated they did not have any way to audit to determine if there were any other instances where the stop date for a medication had not been entered by the pharmacy and refills were sent to the facility.Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.On [DATE] the Regional Nurse interviewed the nurse via phone to question why she reordered the prednisone for Resident #162 even with a stop date of 5 days. The nurse stated that she reordered the medication because it remained active in the system and admitted that she didn't read the order in its entirety prior to reordering. The Regional Nurse educated the Nurse at that time she must read the order in its entirety prior to reordering medications in order to avoid incidents of this nature in the future.The Pharmacy Quality Assurance Manager conducted a root cause analysis on [DATE] that determined that the pharmacy did not enter a stop date upon initial order review and entry on [DATE] that resulted in Resident #162's prednisone being refilled after the prescribed 5 days and without a physician order. The pharmacist that reviewed and entered the order did not populate the stop date during pharmacist verification. The policy that outlines the steps to be followed during the pharmacist verification process was not followed by the pharmacist who reviewed this order. Specifically, upon reviewing the directions ordered for the medication and identifying that an order is for a short-term therapy, the pharmacist must ensure the stop date field in the pharmacy system is populated appropriately. The Pharmacy determined based on the root cause that no systems or processes needed to be revised.Beginning on [DATE], the Pharmacy Quality Assurance Manager and/or Pharmacist-In-Charge started in servicing in-person and via phone all Pharmacists responsible for order entry and medication review regarding the requirement to verify stop dates and enter appropriate stop dates for medications prescribed for a defined duration of therapy. Targeted pharmacist education with an emphasis on the exact field involved that must be populated to prevent subsequent refills. The education for the pharmacists included the expectation that any medication order received without a stop date, but with a specified duration, will be clarified immediately by the pharmacist and assigned an appropriate stop date prior to dispensing. Pharmacy Quality Assurance Manager provided the facility Administrator with a copy of the in-service attendance sheet signifying education regarding the requirement to verify stop dates and enter appropriate stop dates for medications prescribed for a defined duration of therapy. The education will be completed by [DATE]. Any Pharmacist hired after [DATE] will receive the education.Pharmacy leadership will maintain documentation of staff education.On [DATE] the Regional Risk Nurse, Administrator, Staff Development Coordinator, Director of Nursing, Unit Manager and/or [NAME] President of Operations began educating all licensed nurses in-person and via phone regarding importance of ensuring that medications with a stop date are only ordered for the duration within the physicians order and when reordering medications the nurse is to review the order for the medications first to ensure that there is no stop date ordered prior to reordering the medication. All actively working license nurses will be in-serviced by [DATE] regarding the importance of ensuring that medications with a stop date are only ordered/reordered for the duration specified within the physician order.The Staff Development Coordinator will be responsible for tracking nurses not educated by [DATE] or returning from leave to ensure that they are educated prior to taking a resident assignment on the importance of ensuring that medications with a stop date are only ordered for the duration specified within the physicians order and when reordering medications the nurse is to review the order for the medications first to (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ensure that there is no stop date ordered prior to reordering the medication prior to providing services to any residents. Any nurse hired after [DATE] will receive this education prior to taking a resident assignment.The facility alleges removal of immediate jeopardy and compliance on [DATE]Validation of the Immediate Jeopardy (IJ) removal plan was conducted on [DATE].The Consultant Pharmacy Quality Assurance Manager completed an audit of all prednisone orders dated [DATE] through [DATE]. The Director of Nursing, Regional Nurse, and MDS Nurses completed an audit of all current active medication orders to verify stop dates that were entered on each resident's Medication Administration Record. This audit was completed by [DATE]. The consultant pharmacy Quality Assurance Manager and/or PharmacistˆInˆCharge provided education on [DATE] to all pharmacists, both previous and current, regarding verification and entry of medication stop dates. The Regional Risk Nurse, Administrator, Staff Development Coordinator, Director of Nursing, Unit Manager, and/or [NAME] President of Operations provided education to all facility licensed nursing staff on medication stop dates and proper reordering procedures. This education was completed by [DATE]. Interviews with nursing staff and the consultant pharmacist confirmed they attended required inˆservices and, when necessary, participated in audits. Based on review of documentation, interviews, and confirmed implementation of the corrective actions, the immediate jeopardy removal and compliance of date [DATE] was validated.

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, Pharmacist and Physician interviews, the facility failed to ensure the Pharmacist provided monthly medication regimen reviews that included a comprehensive review of the resident's medical record, including the medication administration record to identify medication irregularities. The Pharmacist medication regimen review (MRR) dated [DATE] through [DATE] did not identify irregularities related to ongoing Prednisone (a corticosteroid used to reduce inflammation and suppress an overactive immune system, treating a wide range of conditions including allergies, autoimmune disorders, and respiratory diseases) 20 milligrams (mg) order (3 tablets by mouth with breakfast for 5 days starting [DATE]. The medication regimen review dated [DATE] through [DATE] also did not identify irregularities related to the continued administration of Prednisone 20 mg, 3 tablets daily for 5 days starting [DATE]. Prednisone 20 mg, 3 tabs (60 mg) was administered from [DATE] through [DATE]. On [DATE], Resident # 162 developed cold-like symptoms including wheezing, sneezing, nasal congestion, lethargy, and decreased appetite. The resident was started on Macrobid (antibiotic) for a urinary tract infection. On [DATE], the resident's family requested Resident # 162 be transferred to the hospital due to cough, cold, congestion and a non-productive cough. Resident # 162 was transferred and admitted a with diagnosis of Systemic Inflammatory Response Syndrome (SIRS) (a severe life-threatening bodily response to a non-specific insult or stressor). Resident # 162 did not respond to treatment and expired on [DATE] at 1:33 AM. The facility also failed to have an effective system in place for ensuring pharmacy recommendations were reviewed for Resident #139. This deficient practice affected 2 of 8 residents reviewed for monthly medication regimen reviews (Resident # 162 and #139).Immediate jeopardy began on [DATE], when the Pharmacist failed to identify irregularities in the ongoing Prednisone administration during the monthly medication regimen reviews. The Immediate Jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective.Example #2 was cited at a lower scope and severity of D. Findings included: 1. Resident # 162 was admitted on [DATE] with diagnosis including vascular dementia, chronic congestive heart failure (CHF) (the heart muscle is to weak or stiff to pump blood efficiently), coronary artery disease (CAD) (major blood vessels supplying the heart becomes narrowed or blocked by plaque, restricting the flow of blood to the heart muscle), atherosclerotic heart disease (ASHD) (fatty, cholesterol-rich deposits build up inside the arteries that supply blood to your heart), diabetes mellitus, hypothyroidism (thyroid gland does not produce enough essential hormones), hyperlipidemia, valvular heart disease (conditions affecting the heart and its connected network of blood vessels), chronic obstructive pulmonary disease (COPD) (progressive long term lung conditions that cause irreversible damage to the airway), atrial fibrillation (irregular heartbeat), pulmonary hypertension (small blood vessels in the lungs become narrowed, blocked or destroyed, forcing the heart to work harder), lymphedema (abnormal persistent swelling caused of protein by a build-up rich lymph fluid in the body's soft tissues), hypertension, cerebral vascular accident (CVA or stroke), and viral pneumonia was diagnosed [DATE]. Review of Hospital After Care Summary dated [DATE] revealed Resident # 162 was treated for shortness of breath, dyspnea (difficult or labored breathing), COPD exacerbation and fluid overload (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(body retains water). The emergency room physician prescribed Prednisone 20 milligrams (mg), 3 tablets by mouth with breakfast for 5 days. Review of Resident # 162's physician orders dated [DATE] at 5:02 AM showed Nurse # 1 transcribed the order for Prednisone 20 mg, 3 tablets by mouth with breakfast for 5 days starting [DATE]. Review of Resident #162's Medication Administration Records (MARs) from [DATE] through [DATE] identified that the Prednisone order appeared on the MARs as follows: administration, as follows: Prednisone oral tablet 20 mg, give 3 tablets by mouth one time a day for COPD; take 3 tablets by mouth with breakfast for 5 days; Start Date [DATE] at 8:00 AM. The Prednisone was documented as administered daily from [DATE] through [DATE]. Record review of Resident # 162's pharmacy recommendations dated [DATE] through [DATE] revealed there were no recommendations identified for that month. The medication regimen review dated [DATE] through [DATE] did not include recommendations related to Prednisone. During a telephone interview on [DATE] at 9:56 AM, the Pharmacy Consultant stated that during monthly medication reviews, he reviews the physician orders, and he should have identified the Prednisone 20mg, 3 tablets (60 mg) daily order for 5 days remained as an active order. He stated he did not review the medication administration records, only the physician orders, and he should have identified the irregularities based on the physician orders. Review of the Situation, Background, Assessment, Recommendation (SBAR) written by Nurse # 22 dated [DATE] at 7:12 PM revealed Resident # 162 complained of cold like symptoms (cough, cold and congestion, and a non-productive cough). Nurse # 22 assessed the resident, and family member present requested that Resident # 162 be sent to the emergency department (ED). Resident # 162 was sent to the ED per family request. Review of hospital emergency department (ED) notes dated [DATE] at 7:36 PM revealed ED critical care attestation on [DATE] stated the resident had a high probability of life-threatening deterioration in conditions, at the initial presentation or during the emergency department course due to respiratory failure. Resident # 162 was transferred from the ED and admitted to the medical intensive unit (MIU) for sepsis. Review of Resident # 162's Certificate of Death, with date of death of [DATE] at 1:33 AM, identified the final disease or condition resulting in death as cardiac arrest with pulseless electrical activity, severe sepsis with multi-system organ failure and Respiratory Syncytial Virus. Review of the hospital death summary dated [DATE] indicated Resident # 162 presented to the ED on [DATE] with the chief complaint of shortness of breath and was admitted to MIU with a diagnosis of systemic inflammatory response syndrome (SIRS). Resident # 162 did not respond to treatments for SIRS, and prior discussions with resident and/or family indicated a wish for a peaceful passing with dignity. Resident # 162 was without heart rate or pulse, without respiratory, and had fixed and dilated pupils. Resident # 162 was pronounced dead at 1:33 AM on [DATE]. Discharge diagnoses included RSV pneumonia, respiratory failure, and septic shock. During an interview on [DATE] at 10:47 AM, the Physician stated Prednisone (steroids) taken for any length of time can result in loss of bone, adrenal issues and euphoria and that the residents must be weaned off Prednisone. The Physician reviewed the emergency room notes from [DATE] and stated (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident # 162 had an infection, respiratory distress, and an inflammatory reaction to the Respiratory Syncytial Virus. The Physician stated Prednisone could have reduced Residents # 162's ability to fight infection, and that long-term steroid use decreases the immune response, which could have contributed to her demise. The Physician stated the emergency department (ED) orders should have been followed as written; Prednisone 20 mg, 3 tablets daily for five days. The Physician stated he receives and reviews the pharmacy recommendations monthly and would expected the pharmacist would identify irregularities in medication administration. The Administrator was notified of the immediate jeopardy on [DATE] at 4:05 PM. The facility provided the following credible allegation of immediate jeopardy removal. Identify those residents who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident #162 was admitted to the facility on [DATE] with multiple diagnoses, including COPD, CHF, CAD, diabetes mellitus, atrial fibrillation, vascular dementia, and other chronic conditions. Following an Emergency Department visit on [DATE], the resident was prescribed Prednisone 60 mg daily for five days to treat COPD. The order entered on the electronic Medication Administration Record (eMAR) by the nurse included the prednisone was to be given for 5 days but the nurse failed to schedule the stop date resulting in the medication remaining active and being administered until [DATE]. Due to the extended administration of the prednisone beyond the intended duration, the resident was at risk for adverse effects associated with prolonged steroid therapy. Consultant Pharmacist #1 was responsible for completing monthly Medication Regimen Reviews (MRRs), failed to identify and report the medication irregularity to the facility. A document sent to the facility by the Pharmacist indicated it was created between [DATE] and [DATE], and Resident #162 was listed as having no recommendations. On [DATE], Consultant Pharmacist #1 sent a recommendation regarding Trazodone for Resident #162 but failed to identify the ongoing Prednisone order without a stop date All residents that receive medications have the potential to be affected by the deficient practice. Beginning on [DATE], Consultant Pharmacist #2 (new Pharmacist assigned to the facility) began an audit of all medication orders potentially needing stop dates for all current residents. Once the audit was completed on [DATE] the Consultant Pharmacist submitted the 4 findings / recommendations from the audit to the Regional Nurse. Three of the four residents still remained in facility. The recommendations made for the residents who still remained in the facility were corrected and/or validated with the Provider on [DATE] by the Consultant Nurse and corrected as ordered. Beginning on [DATE], Consultant Pharmacist #2 completed MRRs for November and December of 2025 for all residents that remained in the facility as of [DATE] that will be reflected on the [DATE] Medication Regimen Review Report. Recommendations were sent to facility on [DATE] and reviewed with the Physician. Physician orders for recommendations completed by [DATE]. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On [DATE], the Chief Clinical Officer of consulting pharmacy conducted a root cause analysis and (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	communicated the following. The Chief Clinical Officer for the consultant pharmacy had multiple conversations with Consultant Pharmacist #1 of this facility. The Chief Clinical Officer of the consulting pharmacy believed that the ultimate why is that this was simply a human oversight. Consultant Pharmacist #1 did not identify the stop date for the prednisone when completing the Medication Regimen Reviews in [DATE] and [DATE]. On [DATE] The Chief Clinical Officer for the consulting pharmacy was contacted by the [NAME] President of Operations for the facility and stated it was not that Consultant Pharmacist #1 did not complete the MRRs for all in house residents November/[DATE], he just did not identify the irregularity. Moreover, it was determined that Consultant Pharmacist #1 would benefit from review of all Consultant Pharmacist job responsibilities, additional EHR training and to be put on a Performance Improvement Plan, which has been completed. Training for Consultant Pharmacist #1 and Consultant Pharmacist #2 was started on [DATE] and will be completed by [DATE]. The training includes the following: 1) A live workflow session led by the Chief Clinical Officer, in collaboration with the Consultant Pharmacist focused on pharmacy order entry, MAR review, interventions, allergy review, and documentation requirements. 2) Computer based training that reinforces the responsibilities of the Consultant Pharmacist and improving consistency of use of Electronic Health Record (EHR) with reviewing medication orders. 3) Reinforced that all medications requiring a stop date have a stop date in the order and the range dates are entered into the medication orders. Any new Consultant Pharmacist who comes to the facility will receive this training prior to working in the facility by the Chief Clinical Officer for the consulting pharmacy. These training components will also be incorporated into the standard training modules for all Consultant Pharmacists across the organization moving forward. Beginning [DATE] the Chief Clinical Officer of the Consulting Pharmacy will be working with VP of Quality Assurance of the facility's pharmacy to submit a collaborative QAPI report with root cause analysis and the corrective actions will continue to followed once the full final plan of correction has been accepted. This collaboration is intended to support sustained process improvement with the Consultant Pharmacists. The facility has also implemented an onboarding process for any future Consultant Pharmacists providing services to the facility. Prior to providing consultant pharmacy services, the Consultant Pharmacist will receive education from the Staff Development Coordinator regarding identification of medication regimen irregularities, timely notification to the facility, and expectations related to stop dates and medication duration reviews. On [DATE] the Medical Director and attending physicians were informed by the Administrator of the findings for review and oversight. The facility alleges removal of immediate jeopardy and compliance on [DATE]. Validation of the Immediate Jeopardy (IJ) removal plan was conducted on [DATE]. (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The pharmacy consultant completed a comprehensive audit of all medication orders for all current residents by [DATE]. Four irregularities were identified. The attending physician was notified for clarification of each irregularity. The consultant pharmacist completed monthly medication regimen reviews for all current residents. Reviews included a comparison of physician orders to the Medication Administration Records for the months of [DATE] through [DATE]. All reviews were completed by [DATE]. The Chief Clinical Officer of the consultant pharmacy conducted in-services and assigned additional training to both previous and current consultant pharmacists serving the facility. All required training was completed by [DATE]. Interviews with consultant pharmacists confirmed that they attended the in-services and completed the additional assigned training. Based on review of documentation, staff interviews, and confirmation of completed corrective actions, the Immediate Jeopardy removal and compliance date of [DATE] was validated. 2. Resident #139 was admitted to the facility on [DATE] with diagnoses that included traumatic brain dysfunction, hypertension, diabetes, hyperlipidemia, Alzheimer's disease, and post-traumatic stress disorder. Review of the medical record revealed an order by the Medical Director dated [DATE] for Duloxetine (brand name Cymbalta) HCl capsule delayed release particles 30 mg (milligrams), give one (1) time a day for depression. Review of the pharmacy recommendation dated [DATE] revealed Resident #139 was prescribed Cymbalta 30 milligrams (mg) QD (every day). The pharmacist recommended a dose reduction to 15 mg at HS (hour of sleep). This recommendation was reviewed and signed by the NP on [DATE]. Review of the Medication Administration Record (MAR) dated [DATE] through [DATE] revealed Resident #139 received Duloxetine 30mg, 1 time a day. Review of the MAR dated [DATE] through [DATE] revealed Resident #139 received Duloxetine 30mg, one (1) time a day. Review of the MAR dated [DATE] through [DATE] revealed Resident #139 received Duloxetine 30mg, one (1) time a day. Review of the MAR dated [DATE] through [DATE] revealed Resident #139 received Duloxetine 30mg, one (1) time a day. Review of the Medication Administration Record (MAR) dated [DATE] through [DATE] revealed Resident #139 received Duloxetine 30mg, one (1) time a day. The NP reviewed the recommendation dated [DATE] on [DATE]. The NP then ordered gradual dose reduction of the Duloxetine 30 with a follow up after 2 weeks. An interview was conducted with the Director of Nursing (DON) on [DATE] at 4:20 PM, she stated she would have expected the pharmacy recommendations to be reviewed within 30 days of the recommendation. She added that the pharmacy recommendations were sent to the NP on [DATE] and a gradual dose reduction began on that day per the NP's orders. The DON added pharmacy emailed the recommendations to her; she then printed the recommendations and put them in a folder in the Medical Director's office in the facility for review by the Medical Director or NP. The DON stated she (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety 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, and staff, Physician, Pharmacy Quality Assurance Manager interviews, the facility failed to have effective systems in place to prevent a significant medication error. On [DATE] Resident #162 was seen in the emergency department (ED) for shortness of breath, dyspnea, chronic obstructive pulmonary disease (COPD) exacerbation and fluid overload and returned to the facility just before midnight. The ED Physician prescribed Prednisone 20 mg (milligrams) 3 tablets (total of 60 mg daily) at breakfast for 5 days. Prednisone is a corticosteroid used to reduce inflammation and suppress an overactive immune system, treating a wide range of conditions including respiratory diseases. Possible negative outcomes of receiving 60 mg of Prednisone longer than 5 days may include hyperglycemia (high blood sugar), psychotic disturbance (loss of contact with reality), fluid retention (excess fluid buildup in the body's tissues), decreased ability to fight infection, and a decrease in inflammatory mediators (small molecules and proteins that coordinate the body's immune response to injury or infection). On [DATE] a Nurse transcribed the order into the electronic medical record for Prednisone 20 mg give 3 tablets at breakfast for 5 days; however, the Nurse did not enter a stop date for the order. As a result, nursing staff continued to administer and Resident #162 was administered 60 mg of Prednisone daily from [DATE] through [DATE], totaling 66 days of administration, which was 61 days beyond the ordered stop date. On [DATE] the resident's family requested a transfer to the hospital due to complaints of cough, cold and congestion with non-productive cough. Active hospital problems included SIRS (systemic inflammatory response syndrome- a life threatening medical condition characterized by a widespread inflammatory response throughout the body triggered by infection), RSV (acute bronchiolitis due to respiratory syncytial virus), hypoxia (low levels of oxygen in your body tissues which can cause symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin), and sepsis (life-threatening reaction to an infection that causes your immune system to harm healthy tissues and organs). Resident #162 was transferred to the medical intensive unit for sepsis and did not respond to treatment and expired on [DATE] at 1:33 AM. This deficient practice affected 1 of 8 residents reviewed for significant medication errors (Resident # 162). Immediate jeopardy began on [DATE] when nursing staff continued to administer 61 daily doses of Prednisone 60 mg to Resident #162 after the 5-day stop date without a physician order. Immediate Jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included:Record review of Hospital Physician's Discharge summary dated [DATE] identified that Resident # 162 was admitted on [DATE] and discharged on [DATE]. On admission, Resident # 162 was found to have acute hypoxic respiratory failure (a sudden inability of the lungs to deliver sufficient oxygen to the blood) due to COPD and viral pneumonia. Hospital management included intravenous Methylprednisolone (a corticosteroid that helps reduce inflammation in the lungs and is beneficial for patients with COPD who develop pneumonia), scheduled nebulizer treatments (a machine that converts liquid medication into a fine mist for inhalation, delivering medications directly into to the lungs) and oxygen titrated as needed. Resident # 162 received ceftriaxone (antibiotic) and doxycycline (antibiotic) for possible superimposed bacterial pneumonia; these antibiotics were discontinued. Intravenous Methylprednisolone was initialed, then changed to oral steroids, and was being weaned at discharge. The Physician Discharge Summary included an order for Prednisone 20 mg 0.5 tablet (10 mg) by mouth in the morning for 3 days (start [DATE]), followed by Prednisone 5 mg for 5 days (start [DATE]).Resident # 162 was admitted on [DATE] with diagnosis including vascular dementia, chronic congestive heart failure (CHF) (the heart muscle is to weak or stiff to pump blood efficiently), coronary artery disease (CAD) (major blood (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 staff, Nurse Practitioner (NP) and Physician interviews, the facility failed to obtain daily weights as ordered by the physician. This was for 3 of 8 residents reviewed for the provision of care in accordance with professional standards of practice (Resident #17, Resident #35, and Resident #129). Findings included: a. Resident #17 was admitted to the facility on [DATE] with a diagnosis of congestive heart failure (CHF). A physician's order for Resident #17 dated last revised on 12/5/25 with a discontinue date of 4/14/26 revealed daily weights before breakfast. If (Resident #17) gained 3 pounds (lbs.) in 1 day or 5 lbs in one week, the physician was to be called. Resident #17's comprehensive care plan revealed in part a focus area for potential alteration in hydration related to diuretic (fluid pill) use. The goal was for Resident #17 to remain free from signs and symptoms of fluid overload such as edema (swelling), congestion, and sudden weight gain through the next review. Interventions, dated last revised on 1/6/26, were to monitor Resident #17's weight per the physician's order, notify the physician of any significant weight loss or gain, and to observe for, document, and report any signs of fluid overload to the physician. Resident #17's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. She had no behaviors or rejection of care. She did not have shortness of breath. Her most recent weight was 141 pounds. She did not have weight loss or weight gain of 5 percent (%) or more in the last month or weight loss or weight gain of 10% or more in last 6 months. Resident #17's Medication Administration Record (MAR) for March 2026 revealed a physician's order with a discontinue date of 4/14/26 for daily weights before breakfast. If (Resident #17) gained 3 lbs in 1 day or 5 lbs in one week, the physician was to be called. Resident #17's March 2026 MAR did not reveal any documentation indicating any daily weights had been completed or refused. Resident #17's electronic medical record did not reveal any documentation daily weights were completed or refused on 3/3/26, 3/4/26, 3/6/26, 3/7/26, 3/8/26, 3/9/26, 3/19/26, 3/22/26, 3/27/26, 3/29/26, or 3/30/26. Resident #17's Daily Weight Sheet for March 2026 did not reveal any documentation her daily weights were completed or refused on 3/3/26, 3/4/26, 3/6/26, 3/7/26, 3/8/26, 3/9/26, 3/19 /26, 3/22/26, 3/27/26, 3/29/26, or 3/30/26. On 5/28/26 at 8:50 AM a telephone interview with Nurse #17 indicated she normally worked the overnight shift from 11:00 PM to 7:00 AM. She reported she was assigned to care for Resident #17 on 3/3/36. She stated she did not recall what happened with Resident #17's daily weight on 3/3/26. She reported the Nurse Aide (NA) assigned to Resident #17 on 3/3/26 on the 11:00 PM to 7:00 AM shift would have been responsible for obtaining Resident #17's daily weight at 6:00 AM before breakfast. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #17 indicated she was not responsible for making sure daily weights were obtained. She stated the charge nurse for the 11:00 PM to 7:00 AM shift was responsible for doing that. On 5/29/26 at 1:14 PM a telephone interview with NA #6 indicated she no longer worked for the facility. She stated back in March 2026 she was working the overnight shift from 11:00 PM to 7:00 AM on 3/3/26 and 3/4/26. She stated she didn't recall Resident #17, but she did recall at one point in March 2026, someone told her she had missed obtaining some daily weights. She stated she had not previously been instructed that she was supposed to be getting them. On 5/28/26 at 8:25 AM a telephone interview with Medication Aide (MA) #3 indicated she worked on the 11:00 PM to 7:00 AM shift four to five nights per week. She reported she had been assigned to administer medications, and care for Resident #17 on 3/7/26, 3/27/26 and 3/29/26. She stated the NA assigned to Resident #17 on these dates would have been responsible for obtaining Resident #17's daily weight at 6:00 AM before breakfast. She indicated if there were no weight documented on Resident #17's Daily Weight Sheet for these dates, that meant the assigned NA had not obtained them. MA #3 went on to say if the daily weight was not completed on the 111:00 PM to 7:00 AM, and the Daily Weight Sheet was left blank, the staff on the 7:00 AM to 3:00 PM shift should see that, and get the weight done before breakfast. On 5/28/26 at 11:01 AM a telephone interview with NA #4 indicated she was assigned to care for Resident #17 on the 7:00 AM to 3:00 PM shift on 3/6/26 and 3/29/26. She stated all residents who needed daily weights, including Resident #17, had a Daily Weight Sheet in the Daily Weight Book that was kept at the nurse's station. She reported that if the 11:00 PM to 7:00 AM had not completed and documented a daily weight on Resident #17's Daily Weight Sheet on their shift, she would have been responsible for completing it before breakfast. NA #4 stated she did not know why Resident #17's daily weight had been missed on 3/6/26 and 3/29/26. A physician's order for Resident #17 with a start date of 4/14/26 was for daily weights before breakfast. If (Resident #17) gained 3 lbs in 1 day or 5 lbs in one week, the physician was to be called. Resident #17's April 2026 Medication Administration Record (MAR) revealed a physician's order with a discontinue date of 4/14/26 for daily weights before breakfast. If (Resident #17) gained 3 lbs in 1 day or 5 lbs in one week, the physician was to be called. An additional physician's order with a start date of 4/14/26 for daily weights before breakfast at 6:00 AM. If (Resident #17) gained 3 lbs in 1 day or 5 lbs in one week, the physician was to be called. Resident #17's April 2026 MAR did not reveal any documentation indicating daily weights had been completed or refused on 4/14/26, 4/16/26 or 4/22/26. Resident #17's electronic medical record did not reveal any documentation her daily weights were completed or refused on 4/14/26, 4/16/26 or 4/22/26. Resident #17's Daily Weight Sheet for April 2026 did not reveal any documentation her daily weights were completed or refused on 4/14/26, 4/16/26 or 4/22/26. Multiple attempts for a telephone interview with Nurse #18, who was assigned to care for Resident #17 at 6:00 AM on 4/14/26 and 4/16/26, were unsuccessful. On 5/29/26 at 12:50 PM a telephone interview with NA #5 indicated she was assigned to care for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #17 and would have been responsible for getting Resident #17's daily weight at 6:00 AM on 4/16/26. She stated if there was no weight documented on Resident #17's Daily Weight Sheet for that date, that meant she had not done it. She reported she could not recall the reason why she had not. Resident #17's May 2026 Medication Administration Record (MAR) revealed a physician's order with a start date of 4/14/26 for daily weights before breakfast at 6:00 AM. If (Resident #17) gained 3 lbs in 1 day or 5 lbs in one week, the physician was to be called. Resident #17's May 2026 MAR did not reveal any documentation indicating any daily weights had been completed or refused on 5/4/26, 5/7/26 or 5/15/26. Resident #17's electronic medical record did not reveal any documentation her daily weights were completed or refused on 5/4/26, 5/7/26 or 5/15/26. Resident #17's Daily Weight Sheet for May 2026 did not reveal any documentation her daily weights were completed or refused on 5/4/26, 5/7/26 or 5/15/26. Multiple attempts for a telephone interview with Nurse #18, who was assigned to care for Resident #17 on 5/4/26 and 5/15/26, were unsuccessful. On 5/29/26 at 12:50 PM a telephone interview with NA #5 indicated she was assigned to care for Resident #17 and would have been responsible for getting Resident #17's daily weight at 6:00 AM on 5/4/26. She stated if there was no weight documented on Resident #17's Daily Weight Sheet for that date, that meant she had not done it. She reported she could not recall the reason why she had not. b. Resident #35 was admitted to the facility on [DATE] with diagnoses of congestive heart failure and hypertension (HTN). A physician's order for Resident #35 with a start date of 4/17/26 and a discontinue date of 5/11/26 revealed daily weight for CHF place weight in book. If greater than 3 pounds (lbs.) (weight gain) in 2 days contact (provider) if more than 5 lbs. (weight gain) in a week contact (provider) for further instructions. Weigh every morning at 6:00 AM. If (Resident #35) refuses, document refusal. Resident #35's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. He did not reject care. He did not have shortness of breath (SOB). His most recent weight was 189 pounds. He did not have weight loss or weight gain of 5 percent (%) or more in the last month or weight loss or weight gain of 10% or more in last 6 months. Resident #35's comprehensive care plan revealed a focus area dated as initiated on 4/21/26 of at risk for alteration in cardiovascular status. The goal was for Resident #35 to not have any decline in function due to his cardiac conditions through the next review. Interventions included to assess for shortness of breath (SOB) and edema, monitoring for and reporting any significant changes in condition or weight changes to the physician. Resident #35's April 2026 Medication Administration Record (MAR) did not reveal any documentation indicating daily weights had been completed or refused on 4/17/26, 4/21/26, or 4/25/26. Resident #35's electronic medical record did not reveal any documentation his daily weights were completed or refused on 4/17/26, 4/21/26, or 4/25/26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #35's Daily Weight Sheet for April 2026 did not reveal any documentation his daily weights were completed or refused on 4/17/26, 4/21/26, or 4/25/26. On 5/28/26 at 9:22 AM an interview with Nurse #19 indicated she would have been covering and administering medications to Resident #35 on the 11:00 PM to 7:00 AM shift on 4/17/26, 4/21/26 and 4/25/26. She stated if there were no weights documented on his MAR for those days, that meant the weights weren't done. She indicated there were some Nurse Aides (NAs) who would get the daily weights, and some who would not. Nurse #19 stated she had communicated to the Director of Nursing (DON) that weights weren't getting done daily as ordered, and she got a message back on her phone that daily weights needed to be done as ordered. On 5/29/26 at 4:07 PM a telephone interview with NA #7 indicated she would have been responsible for obtaining Resident #35's daily weight on her shift (11:00 PM to 7:00 AM) on 4/17/26, 4/25/26, and 4/29/26. She reported she knew what residents needed daily weights because she listened to report at the nurse's station and it would be told to her there, looked in the weight book at the nurse's station, or the nurse would tell her. She stated when she got a weight, she either documented it in the weight book or told the nurse. NA #7 reported if there was not a weight documented for Resident #35 on 4/17/26, 4/25/26 or 4/29/26 that meant the weight wasn't done. She stated she could not recall ever having a problem getting a resident's daily weight on her shift. c. Resident #129 was admitted to the facility on [DATE] with a diagnosis of myocardial infarction (heart attack caused by partial blockage of a coronary artery), stroke, and hypertension. A physician's order for Resident #129 dated 4/7/26 revealed daily weights at 6:00 AM. If the resident gained 3 pounds in one day or 5 pounds in one week, the physician was to be called. Resident #129's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired. She had no behaviors or rejection of care. She did not have shortness of breath. Her most recent weight was 92 pounds. She did not have weight loss or weight gain of 5 percent (%) or more in the last month or weight loss or weight gain of 10% or more in last 6 months. Resident #129's comprehensive care plan revealed that she was at risk for impaired cardiovascular status related to hypertension and hyperlipidemia. Interventions, dated last revised on 5/11/26, were to monitor Resident #129's weight and notify the physician of any significant weight loss or gain. Resident #129's Medication Administration Record (MAR) for April 2026 revealed a physician's order for daily weights at 6:00 AM. If the resident gained 3 pounds in one day or 5 pounds in one week, the physician was to be called. Resident #129's weights were not documented on the MAR. Resident #129's electronic medical record did not reveal any documentation daily weights were completed or refused on 4/8/26, 4/9/26, 4/10/26, 4/13/26, and 4/14/26. Resident #129's Daily Weight Sheet for April 2026 did not reveal any documentation her daily weights were completed or refused on 4/8/26, 4/9/26, 4/10/26, 4/13/26, and 4/14/26. On 5/29/26 at 8:20 AM a telephone interview with Nurse #19 indicated she normally worked the overnight shift from 11:00 PM to 7:00 AM. She reported she was assigned to care for Resident #129 on 4/8/26 and 4/9/26. Nurse #19 stated that Nurse Aides were responsible for obtaining weights, and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she would record the weight value in the MAR. She further stated if there were no weights documented on the MAR for the mornings of 4/8/26 or 4/9/26, that meant the weights were not done. She indicated there were some Nurse Aides who would get the daily weights, and some who would not. Nurse #19 indicated she had communicated to the Director of Nursing #1 that weights were not getting done daily as ordered, and she got a message back on her phone that daily weights needed to be done as ordered. Multiple telephone interview attempts were made to Nurse Aide #8, who was assigned to Resident #129 from 11:00 PM on 4/7/26 until 7:00 AM on 4/8/26; however, she was unable to be reached during the investigation. On 5/29/26 at 9:51 AM an interview with Nurse Aide #9 revealed that she was assigned to Resident #129 from 11:00 PM on 4/8/26 until 7:00 AM on 4/9/26 and from 11:00 PM on 4/9/26 until 7:00 AM on 4/10/26. She indicated that some weights could be done with a wheelchair and others needed the mechanical lift. Nurse Aide #9 stated that Resident #129 required the mechanical lift for daily weights. There was a time (dates unknown) when she did not know Resident #129 required daily weights. However, as soon as she was informed, she collected the daily weight measurements as ordered. Nurse Aide #9 reviewed the missing daily weights on 4/9/26 and 4/10/26, Nurse Aide #9 indicated that she might have forgotten to write down the weight values on the Daily Weight Sheet at the nurses' station, but there was ample time and opportunity to retrieve daily weights during the overnight shifts. Multiple telephone interview attempts were made to Nurse #18, who was assigned to Resident #129 from 11:00 PM on 4/9/26 until 7:00 AM on 4/10/26 and 11:00 PM on 4/13/26 until 7:00 AM on 4/14/26; however, she was unable to be reached during the investigation. Multiple telephone interview attempts were made to Nurse Aide #10, who was assigned to Resident #129 from 11:00 PM on 4/12/26 until 7:00 AM on 4/13/26; however, she was unable to be reached during the investigation. Multiple telephone interview attempts were made to Nurse Aide #11, who was assigned to Resident #129 from 11:00 PM on 4/13/26 until 7:00 AM on 4/14/26; however, she was unable to be reached during the investigation. On 05/29/2026 at 10:26 AM a telephone interview with Nurse #13 revealed that he worked with Resident #129 from 11:00 PM on 4/12/26 until 7:00 AM on 4/13/26. He indicated that Nurse Aides retrieved the daily weights, and he documented the values in the MAR. Nurse #13 could not recall the details of 4/13/26 or why the MAR was blank for daily weights on that day. Resident #129's May 2026 MAR revealed a physician's order with a start date of 4/7/26 for daily weights at 6:00 AM. If the resident gained 3 pounds in one day or 5 pounds in one week, the physician was to be called. Resident #129's May 2026 MAR did not reveal any documentation indicating any daily weights had been completed or refused on 5/4/26. Resident #129's electronic medical record did not reveal any documentation her daily weights were completed or refused on 5/4/26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #129's Daily Weight Sheet for May 2026 did not reveal any documentation her daily weights were completed or refused on 5/4/26. On 5/29/26 at 10:08 AM a telephone interview with Nurse Aide #13 indicated she was assigned to care for Resident #129 and would have been responsible for getting Resident #129's daily weight at 6:00 AM on 5/4/26. She normally retrieved the daily weights when she arrived for her shift at 11:00 PM because it was more difficult to do so during rounds at 6:00 AM. Nurse Aide #3 indicated she floated to all halls and was not aware that Resident #129 required a daily weight. Multiple telephone interview attempts were made to Nurse #24, who was assigned to Resident #129 from 11:00 PM on 5/3/26 until 7:00 AM on 5/4/26; however, he was unable to be reached during the investigation. On 5/28/26 at 9:44 AM an interview with the Director of Nursing (DON) #1 indicated if a resident had a physician's order for a daily weight, the night shift nurse or Nurse Aide normally obtained this at 6:00 AM. She reported the daily weight result would be documented on the residents Daily Weight Sheet that was kept in the Weight Book at the nurse's station. She stated if the resident's daily weight was not obtained by the night shift (11:00 PM to 7:00 AM), the nurse or NA on the day shift (7:00 AM to 3:00 PM) should obtain the resident's weight before breakfast. The DON indicated she was aware that there were residents whose daily weights had been missed and had spoken with some night shift nurses and NAs regarding ensuring the weights got done. She stated that the purpose of daily weights was to monitor fluid weight gain in resident's who had a diagnosis of congestive heart failure (CHF). She reported that in addition to daily weight monitoring, nurses also monitored these residents for any shortness of breath or other signs of fluid overload such as edema and would notify a provider immediately of these symptoms. On 5/28/26 at 12:15 PM an interview with the Nurse Practitioner (NP) indicated daily weights were important for residents who were diagnosed with CHF as they tracked whether a potentially significant fluid increase was happening which would allow him to address the issue before any complications would arise. He reported that he knew which residents needed daily weights, and he looked at the weight book himself five days per week when he was present in the facility. He indicated he had at times noticed missing daily weights for residents who had daily weights ordered. He stated if there was a resident that was particularly fragile and he didn't see a daily weight he spoke with the staff. The NP indicated he was not aware of any resident who had an exacerbation of congestive heart failure that required hospitalization or any harm to a resident because a daily weight was not obtained. He reported that the nurses were very good at monitoring other signs of fluid overload such as edema or shortness of breath and notifying him immediately. On 05/28/2026 at 12:28 PM an interview with Resident #17's, Resident #35's, and Resident #129's Physician revealed daily weight monitoring for residents with CHF was important because rapid weight gain indicated worsening fluid overload status. He stated this information could alert the provider who could then determine what other measures or further testing might be needed. He reported that the NP was in the facility five days per week and followed residents with CHF closely. The Physician stated the nurses were very good about immediately notifying a provider if a resident had signs of worsening CHF, or fluid overload such as shortness of breath, or edema. He indicated he was not aware of any resident that required hospitalization or any harm to a resident because a daily weight was not obtained. On 05/29/2026 at 2:12 PM an interview with the Administrator indicated he was relieved to hear that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the providers had not determined any adverse consequences because of missed daily weights. He reported that there was never any instance where the facility was not staffed or mechanically equipped to get residents' daily weights as ordered by the Physician. He stated the facility needed structures and a process implemented to hold staff accountable for following physician's orders. On 05/29/2026 at 2:40 PM a follow-up interview with the Administrator indicated he had been aware that there were issues with residents not having daily weights completed. He stated the facility did not have a plan of correction in place for the issue but were working on it.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of nutritional approaches (Resident #79) and intravenous (into a vein) access (Resident #180). This was for 2 of 62 residents whose MDS assessments were reviewed. Findings included: 1. Resident #79 was admitted to the facility on [DATE]. A Hydration Evaluation (an assessment of dehydration risk) form for Resident #79 dated 3/24/26 revealed in part Resident #79 was at risk for dehydration related to medications received, the need for feeding assistance, and the presence of a pressure wound. The evaluation indicated she would benefit from additional hydration support. A physician's order for Resident #79 with a start date of 3/24/26 was for Resident #79 to receive Sodium Chloride 0.9 percent (%) solution use 60 milliliters per hour (ml/hr) intravenously for the diagnosis of rehydration for 1 day, total of 1000 ml. Discontinue dermoclysis (a medical technique for administering fluids or medications via needle infusion into subcutaneous (the layer of fat just under the skin) tissue when IV access was difficult to establish) upon completion. A nursing progress note for Resident #79 dated 3/24/26 at 12:51 PM written by Nurse #20 revealed in part while Resident #79 was lying in bed, a dermoclysis infusion needle was placed in her left abdomen. It flushed without difficulty. Normal (0.9%) Saline (Sodium Chloride) fluids were initiated at 11:10 AM. Resident #79 tolerated this well. Resident #79's March 2026 Medication Administration Record (MAR) revealed documentation by Nurse #16 on 3/24/26 at 3:05 PM that 200 ml of Sodium Chloride Solution 0.9 % was administered to Resident #79 via dermoclysis. Resident #79's quarterly Minimum Data Set (MDS) assessment dated [DATE] did not indicate she had received nutritional approaches of parenteral (anything situated or occurring outside the digestive tract) or intravenous (within a vein) feeding. On 5/29/26 at 9:09 AM an interview with Nurse #16 indicated Nurse #20 was the facility's IV therapy nurse. She reported Nurse #20 initiated the dermoclysis for Resident #79 on 3/24/26 in accordance with the physician's order. Nurse #16 stated after the initiation of the therapy, she monitored the administration of the fluids and documented the amount infused on Resident #79's MAR on 3/24/26. On 5/29/2026 at 8:53 AM an interview with the MDS Coordinator indicated she coded the nutritional approach section of Resident #79's MDS assessment dated [DATE]. She reported that the facility had an audit of their MDS process by an outside company. She stated that as a result of this audit, she had been instructed that she was not allowed to code this section unless a resident had a critical blood urea nitrogen (BUN is a laboratory test that measures the amount of a waste product in blood created by the liver). The MDS Coordinator indicated that because Resident #79 did not have any laboratory testing done during the look back period, she did not code Resident #79's MDS assessment dated [DATE] to reflect the fluids she received via dermoclysis on 3/24/26. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/26 at 2:12 PM an interview with the Administrator indicated MDS assessments should be coded accurately. 2. Resident #160 was admitted to the facility on [DATE]. Her active diagnoses included respiratory failure, anemia, hypertension, peripheral vascular disease, malnutrition, dysphagia, and hypokalemia. Resident #160's orders revealed on 4/14/26 an order was written to insert peripheral intravenous (IV) catheter (a small, flexible tube that healthcare providers insert into a vein) one time only for hydration. On 4/14/26 she was also ordered sodium chloride solution 0.9 % use 75 milliliters/hour intravenously for 24 hours for re-hydration for 1 day. Resident #160's Medication Administration Record for 4/2026 revealed this order was on the Medication Administration Record and had a check mark on the order on the date 4/14/26 indicating this order was completed as ordered by the physician. Resident #160's quarterly Minimum Data Set assessment dated [DATE] revealed she was not assessed to have intravenous access within the prior 14-day lookback period. During an interview on 5/27/26 at 10:43 AM MDS Coordinator reported that the facility had an audit of their MDS process by an outside company. She stated that as a result of this audit, she had been instructed that she was not allowed to code this section unless a resident had a critical blood urea nitrogen (BUN is a laboratory test that measures the amount of a waste product in blood created by the liver). She concluded this was why IV Access was not captured on the MDS assessment. During an interview on 5/27/26 at 11:00 AM the Administrator stated MDS assessments should accurately reflect resident intravenous status.

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	345195	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgecombe Health Center by Harborview	1000 Western Boulevard Tarboro, NC 27886

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident, Speech Therapist, and staff interviews, the facility failed to serve food in a form that met the resident's needs for 1 of 1 resident (Resident #14) reviewed. Resident #14 had been ordered food that was pureed texture and was observed to receive a soaked dinner roll.The findings included: Resident #14 was admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), dementia, Alzheimer's disease, and failure to thrive. A physician's order for a pureed texture and thin liquids consistency was ordered for Resident #14 on 4/22/26. A review of Resident #14's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident to have the ability to understand others and to make herself understood. The MDS indicated she was severely cognitively impaired and required setup or clean-up assistance when eating. Resident #14 had a swallowing disorder and was on a mechanically altered diet without any weight changes. A review of Resident #14's Care Plan, last revised on 4/27/26, revealed that she was at risk for alternation in nutritional status related to dementia, depression, poor intake, and adult failure to thrive. Interventions included: diet as ordered. An observation and interview with Resident #14 were conducted on 5/26/26 at 12:00 PM. She was observed sitting up in her wheelchair beside her bed with the lunch meal tray in front of her on the bedside table. One of the items did not look puree consistency. The meal ticket called the food item a soaked dinner roll. The top of the soaked dinner roll was hard, and it appeared wet in a clear syrupy liquid. This writer took a fork and attempted to mix the food item, but it remained in whole form. Two family members were in the room and everyone, including Resident #14, did not know what the food item was and never saw it before. Resident #14 did not eat the soaked dinner roll. The soaked dinner roll recipe provided by the facility revealed the following preparation instructions: Remove crust from the bread and lay in a single layer on a shallow pan. Blend commercial thickener with a small amount of water, broth, or milk to meet desired consistency. Pour slurry (liquid mixture) over bread, and ensure edges are completely soaked. Refrigerate for 1-2 hours. Use the Fork Drip Test and Spoon Tilt test to confirm the texture was within the International Dysphagia Diet Standardization Initiative (IDDSI) pureed food specifications and if hard parts formed during sitting. The Fork Drip test should be performed by placing a small amount of food on the prongs of a fork and observe if it drips slowly in dollops for pureed consistency. The Spoon Tilt test should be performed by placing a small amount of food on a spoon and observe if the food holds its shape and falls off cleanly or sticks to the spoon (that would mean the consistency was too thick). On 5/28/26 at 12:09 PM the Dietary Manager was interviewed, and she revealed that the soaked dinner roll was approved by whoever made the menu. She described the food item as a dinner roll soaked in thickener solution, and eventually it was supposed to become soft. On 5/28/26 at 1:19 PM Registered Dietitian (RD) #1 revealed that she was the assigned RD for the facility. She indicated that she did not know what a soaked dinner roll was and had never seen the facility serve this food item. RD #1 stated that her supervisor oversaw the facility menus. On 5/28/26 at 1:21 PM RD #2 was interviewed and revealed that the facility menus were managed by the corporate division of the facility. She indicated that a soaked dinner roll was also called a slurried dinner roll, which was bread soaked in milk. The National Director of Dining Services was interviewed on 5/28/26 at 1:33 PM. She revealed that she was the member of corporate who managed the facility menus. She was in the process of changing the menus from fall/winter cycle to summer/spring cycle. She indicated that a soaked dinner roll used to be called a slurry, which was a dinner roll soaked in milk to make it soft. On 5/28/26 at 1:51 PM the Speech Therapist was interviewed, and she revealed that she had never seen or worked with a soaked dinner roll when evaluating a resident's swallowing ability. She stated if a diet specified puree consistency, then it should be presented as puree consistency. If the food item must be chewed, then it would not be considered puree. Resident #14 was picked up by Speech (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Therapy because nursing reported that she was having more difficulty with eating. Resident #14 can feed herself but preferred the pureed diet because it was easier for her to chew. She spit out mechanical soft consistency foods or pocketed foods in her cheeks because it was harder to chew mechanical soft foods. The Speech Therapist indicated that Resident #14 was not at risk for a choking incident. She just would not be able to consume the soaked dinner roll calories on the lunch meal tray served on 5/26/26. Nurse Aide #1 was interviewed on 5/28/26 at 2:17 PM. She indicated that she worked Resident #14's hall on 5/26/26 during lunch service. Nurse Aide #1 stated that on 5/26/26, when Resident #14 received a soaked dinner roll on her lunch meal tray, the family members in her room were very upset because they thought it was a choking hazard. They requested for Resident #14 to never receive a soaked dinner roll again. Nurse Aide #1 stated she had never seen a soaked dinner roll served on a meal tray before, and she had fed residents with a puree diet order. Nurse Aide #1 indicated that Nurse Aide #2 delivered the lunch meal tray to Resident #14 on 5/26/26. On 5/28/26 at 2:19 PM Nurse Aide #2 revealed that before 5/26/26, she had never seen a soaked dinner roll served on a resident's meal tray before. She stated it looked like a dinner roll with water filled halfway in a soup dish. The top of the roll was brown and crusty and was still formed but soggy. Nurse Aide #2 stated that she told Nurse #25 about Resident #14's soaked dinner roll, and Nurse #25 instructed another staff member to tell the kitchen to not send anymore soaked dinner rolls for puree diets because it was not the correct consistency.Nurse #25 was interviewed on 5/28/26 at 3:58 PM. She revealed that she was assigned to Resident #14 on 5/26/26 during the lunch meal, but she could not recall any issue related to a soaked dinner roll. Nurse #25 indicated that it was possible another nurse was notified by Nurse Aide #2. On 5/29/26 at 2:08 PM the Administrator revealed that the soaked dinner roll should have been pureed prior to Resident #14's lunch meal delivery. New menus were in process, and the soaked dinner roll has been eliminated.