STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Forest Nursing and Rehabilitation Center	1304 SE Second Street Snow Hill, NC 28580

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least eight consecutive hours per day seven days a week for 3 of 119 days (1/4/26, 2/8/26 and 3/15/26) reviewed for sufficient staffing.The findings included:A review of the daily posted nursing staff forms, daily nursing staff assignment sheets, and staff clock-in sheets from 1/1/26 through 3/31/26 and 5/18/26 through 6/18/26 was conducted.A review of the daily census posting sheets for 1/1/26 through 3/31/26 and 5/18/26 through 6/18/26 revealed no RN coverage for eight consecutive hours on 1/4/26, 2/8/26, and 3/15/26.On 6/18/26 at 9:53 AM the scheduler was interviewed. She could not recall the details of the dates of 1/4/26, 2/8/26, and 3/15/26 without any RN coverage. The scheduler indicated that she would have notified the Director of Nursing (DON) immediately if she was aware of no RN coverage for those days. On 6/17/26 at 2:51 PM the DON was interviewed. She could not provide a reason why there was no RN coverage on 1/4/26, 2/8/26, and 3/15/26. However, she stated the scheduler should have notified her, and the facility would have provided RN coverage. On 6/18/26 at 10:51 AM the Administrator was interviewed. She revealed that she was unaware that there was not RN coverage for 3 days in the Federal Fiscal Quarter 2 (January, February, and March) of 2026 (1/4/26, 2/8/26, and 3/15/26). The Administrator stated that there should have been RN coverage 8 hours every day 7 days a week.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to provide an environment free of wall damage (room [ROOM NUMBER], 707, and #710), failed to ensure pipes around hand washing sinks were sealed (room [ROOM NUMBER] and #307) and failed to provide privacy curtains free of stains (Rooms #408) for 6 of 26 rooms on 4 of 6 hallways reviewed for the environment. The findings included: 1A. An observation of room [ROOM NUMBER], which was occupied, took place on 6/15/26 at 11:58 AM and revealed deep scratch marks on the wall beside the residents bed, including a brownish-red dried substance in one of the marks and a large approximately 2 inch wide by 18 inch long by 1/2 deep gash in the sheetrock on the wall at the head of the bed. 1B. An observation on 6/16/26 at 2:45 PM of room [ROOM NUMBER], which was occupied, revealed the wall behind the head of the bed had 3 approximately 2 feet long gouges in the sheet rock and the paint was gone in an area approximately one foot in diameter. 1C. An observation of room [ROOM NUMBER], which was occupied, was conducted on 6/16/26 at 2:50 PM and revealed an area exposing brown paper and gouges approximately 2 feet long and the white sheet rock was visible. 1D. Observation of room [ROOM NUMBER], which was occupied, was conducted on 6/15/26 at 12:45 PM revealed the pipe supplying water to the handwashing sink was not sealed, leaving a large gap around the pipe coming out of the wall. The gap was large enough to place a finger in between the sheetrock and the pipe. 1E. Observation of room [ROOM NUMBER] which was occupied, was conducted on 06/15/26 at 12:42 PM revealed the pipe supplying water to the handwashing sink was not sealed, leaving a large gap around the pipe coming out of the wall. The gap was large enough to place a finger in between the sheetrock and the pipe. An interview with Nurse #3 was conducted on 6/16/26 at 2:45 PM; she stated she did not know how long the walls in rooms #707 and #710 had gouges in them. An interview and observation in the rooms with the Maintenance Director was conducted on 6/16/26 at 3:00 PM. He stated the deep marks in the wall in room [ROOM NUMBER], which had dried brown-red substances, could harbor pests and various substances including bodily fluids. The Maintenance Director also stated the gaps around the handwashing sink pipes could allow pests to enter the building. An interview with the Administrator was held on 6/16/26 at 3:25 PM. The Administrator stated the pest control company would notify the facility staff if there were any pest concerns. She added she was not sure if pests could enter the rooms through the approximate 1/2 inch open area around the pipes coming in through the wall to the handwashing sinks in rooms #106 and #307. The Administrator added the rooms with the gashes in the sheet rock could harbor bodily fluids. The Administrator (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed the brownish-red substance and stated she could not identify its origin. In a follow-up interview with the Administrator on 6/18/26 at 10:30 AM; she stated the maintenance director had made list of rooms in need of repair. The Administrator added that she had expected the rooms to be repaired in the order listed by priority and the piping under the sinks should have been repaired when staff first noticed they were not sealed properly. 2. During an observation on 6/15/26 at 11:07 AM room [ROOM NUMBER]'s privacy curtain between resident beds was observed to have a dark brown-red splatter stain near the base of the curtain. The stain consisted of splashed dried brown-red substance over approximately 2 inches by 4 inches of the curtain. Resident #11's Minimum Data Set assessment dated [DATE] revealed Resident #11 was assessed as cognitively intact. During an interview on 6/15/26 at 11:02 AM Resident #11 stated the curtain between him and his roommate had the stain on it for at least a month or two. The Resident added that he preferred to keep the curtain pulled at all times between him and his roommate. During an observation on 6/16/26 9:57 AM observation of privacy curtain between resident beds still had the brown-red splatter stain on the curtain. During an interview on 6/16/26 3:39 PM the Housekeeping Supervisor stated housekeeping staff were responsible for the cleanliness of the resident privacy curtains. She stated that when her staff clean resident rooms, they should check the privacy curtains and any curtains that were visibly dirty should be removed. She further stated she was unclear if during rounds the staff would notice that curtain and would then have pulled the curtain to clean it. She stated nurse aides also notify housekeeping staff if any curtains need to be cleaned. Curtains were also cleaned when a room was deep cleaned and as needed. Upon observation of the curtain the housekeeping supervisor stated curtains visibly soiled with liquid splatter should be replaced and cleaned immediately. During an interview on 6/16/26 at 3:54 PM the Administrator stated if privacy curtains were visibly soiled with dried liquid splatter, they should be changed and cleaned.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Physician #1, Physician #2, Hospice staff interview and staff interviews the facility failed to implement effective interventions to promote bowel movements. Hospice orders on 2/7/26 included the addition of a stool softener as needed; however, the bowel regimen did not begin until 2/18/26 when the resident returned from the emergency department (ED) on 2/18/26. A pelvic x-ray was performed in the ED on 2/18/26 that displayed fecal impaction. This was for 1 of 1 resident (Resident #16) reviewed for professional standards.The findings included:Resident #16 was readmitted to the facility on [DATE] with diagnoses included failure to thrive, dementia, chronic respiratory failure, diabetes, and congestive heart failure. Resident #16 was admitted to hospice on 2/7/26. She went to the ED on 2/18/26 after a fall and returned to the facility the same day.Resident #16's care plan revised on 2/6/26 included hospice care due to a terminal decline.Interventions included: Consult with hospice and physician regarding pain management, diet as ordered, encourage and assist with feeding as needed, encourage and assist with good oral hygiene, notify the physician of significant changes, and turn and reposition frequently.The Hospice Physician Order form dated 2/7/26 by the Hospice Nurse revealed that Resident #16 was admitted to hospice for hypertensive heart disease with heart failure and was to begin receiving Senna Plus 8.6-50 milligrams (mg) tablet 2 tablets daily as needed for constipation the same day. This order was not implemented until 2/18/26 per Resident #16's medical record.The significant change Minimum Data Set (MDS) assessment dated [DATE] documented Resident #16 was severely cognitively impaired and was always incontinent of bowel and bladder. She was totally dependent on staff for toileting. The bowel movement activity history for Resident #16 from 2/4/26 - 2/18/26 revealed that she did not have a bowel movement on the following dates: 2/4/26, 2/6/26, 2/7/26, 2/9/26 (no documentation), 2/10/26, 2/11/26, 2/12/26, 2/15/26, and 2/16/26.The facility standing orders included instructions for if a resident did not have a bowel movement in 3 days, then nurses were to first give the resident 30 milliliters (mL) of Milk of Magnesia. If no results in 12 hours, then give a Fleets Enema. If still no results, then give 1,000 mL of the Soap Suds Enema. If there were still no results, then the provider would need to be notified.The Emergency Department Provider Note for Resident #16 dated 2/18/26 revealed that an xray of the pelvis performed on 2/18/26 showed that the rectum was distended with a large stool ball and significantly dilated measuring up to 10.3 centimeters in diameter. The appearance of the included rectum suggested high-grade fecal impaction. The February 2026 medication administration record (MAR) for Resident #16 revealed that she began receiving Senna Plus 8.6-50 mg tablet 2 tablets daily as needed for constipation on 2/18/26. On 6/16/26 at 3:58 PM Nurse #4, the evening nurse (3:00 PM - 11:00 PM) assigned to Resident #16 from 2/9/26 - 2/12/26, revealed the Nurse Aides were responsible for tracking bowel activity, and if a resident did not have a bowel movement for 24 hours, they needed to notify the nurse. Hospice would have needed to be contacted first if Resident #16 did not have a bowel movement for 24 hours. All communication with hospice would have been documented in the progress notes. Nurse #4 indicated that hospice was responsible for ordering the bowel regimen. Nurse #4 stated she could not recall the details of 2/9/26 - 2/12/26.Multiple attempts to contact Nurse #6, who worked overnight 11:00 PM - 7:00 AM on 2/9/26 and 2/10/26, were conducted; however, she was unable to be reached during the investigation. The Hospice Nurse, who visited Resident #16 in the facility on 2/9/26 and 2/11/26, was interviewed on 6/17/26 8:41 AM. She revealed that she had never given any bowel regimen to Resident #16 on 2/9/26 or 2/11/26. If Resident #16 did not have any symptoms or complaints of constipation, nursing might have not notified hospice. The Hospice Nurse indicated that she usually asked the facility nurses about intake, bowel movements, and other pertinent information related to Resident #16 prior to seeing the resident. The expectation would be for nursing to contact hospice after hours or during visits if constipation was an issue. A bowel regimen would then be ordered, which would be managed by hospice.On (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/17/26 at 9:54 AM Nurse Aide #1, who worked with Resident #16 during the day 7:00 AM - 3:00 PM from 2/9/26 - 2/12/26, was interviewed. She revealed that all bowel activity during her shift needed to be documented. If Resident #16 did not have a bowel movement, then she would have notified the nurse. If the documentation was missing from the bowel movement activity history, then it would be assumed that Resident #16 did not have a bowel movement during her shift. Nurse Aide #1 stated that she could not recall the details of Resident #16's bowel activity from 2/9/26 - 2/12/26.Nurse #7, who worked with Resident #16 during the day 7:00 AM - 3:00 PM on 2/9/26 and 2/12/26, was interviewed on 6/17/26 at 10:30 AM. She revealed that she worked on all halls of the facility. If a resident reported not having a bowel movement in 3 days, an alert would pop up in the orders section of the medical record. First, she would look to see if an order for bowel regimen was already in place. She would also communicate with the nursing staff, and if a Nurse Aide worked with a resident on a regular basis, then they would notify her there was no bowel movement during their shift. Regardless of the alert, she would need to research each resident's bowel movement activity. If Resident #16 did not have a bowel movement for 4 days, then a staff member should have implemented a bowel regimen. If the bowel movement activity history was blank for a specific day, then it was safe to assume that there was no bowel movement for that day. Nurse #7 indicated that she could not recall the details of Resident #16's bowel movement activity in February 2026.An interview with Physician #2, Resident #16's assigned doctor, was interviewed on 6/18/26 at 10:24 AM. He revealed that Resident #16 did not have a bowel regimen implemented until 2/18/26. If Resident #16 did not have a bowel movement for 3-4 days, then he would expect the nursing staff to notify him and follow the standing orders. Physician #2 indicated that he did not feel that Resident #16 had a fecal impaction on 2/18/26 while at the ED. She did not display any symptoms, and the final diagnosis from the ED report listed constipation.Physician #1, the Medical Director, was interviewed on 6/18/26 at 9:25 AM. He revealed that the risks of fecal impaction are small bowel obstruction, significant pain/discomfort, and could affect quality of life. Physician #1 stated that the nursing staff should have notified a provider or the Director of Nursing if Resident #16 did not have a bowel movement for 3-4 days. Then bowel regimen orders could have been provided. The Director of Nursing was interviewed on 6/18/26 at 10:42 AM. She revealed that the nurses assigned to Resident #16 should have implemented the standing orders if Resident #16 did not have a bowel movement for 3 days, and the physician should have been notified.On 6/18/26 at 10:53 AM The Administrator was interviewed. She revealed that the bowel regimen orders from hospice on 2/7/26 should have been implemented when the resident was admitted to hospice on 2/7/26.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident, staff and physician interviews the facility failed to arrange podiatry services for 1 of 1 resident reviewed for foot care (Resident #89).Findings included:Resident #89 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease.Resident #89's provider note dated 4/22/26 revealed the physician documented Resident #89 reported overgrown and protruding toenails causing discomfort and difficulty with trimming and was requesting podiatry evaluation. The physician documented he would order a podiatry consult for nail care and evaluation.Resident #89's orders revealed on 4/22/26 he was ordered to have a podiatrist consult. Nurse #2 was documented as the nurse who confirmed the order.Resident #89's quarterly Minimum Data Set assessment dated [DATE] revealed he was assessed as moderately cognitively impaired. He had no moods or behaviors and was assessed to be dependent on staff for personal hygiene.Review of the resident list seen by podiatry on 5/28/26, provided by the Administrator, revealed Resident #89 had not been seen by podiatry. This list contained the names of residents who were seen by podiatry on 5/28/26.During an interview on 6/16/26 at 11:01 AM Resident #89 stated sometime a couple of months ago he notified the physician he needed to see podiatry and the physician agreed with him. He further stated he was told the physician would put in a referral but had heard nothing since. He stated he had not had any negative outcomes as he was unable to feel very well, but it was slightly uncomfortable and would be nice to be seen by podiatry. During observation on 6/17/26 at 9:27 AM Resident #89's feet were observed and the left foot, third toe toenail was observed to extend away from his toe approximately 3/4 of an inch. Resident #89's toenails were observed to have not been trimmed.During an interview on 6/17/26 at 8:16 AM Nurse #2 stated the Staff Development Coordinator (SDC) was the staff member who works with the in-house podiatry visits to ensure the residents in the facility who need to be seen were seen while podiatry was in the facility. She stated she would verbally let the SDC know if a resident needed to see a podiatrist and then the SDC either put the resident on the list to be seen by podiatry or they set up an appointment to be seen outside the facility if the resident needs to be seen prior to the next podiatry visit. She further stated she did not remember confirming the order in Resident #89's chart and did not inform the SDC that Resident #89 needed to be seen by a podiatrist.During an interview on 6/17/26 at 8:26 AM the Staff Development Coordinator stated she was not aware Resident #89 had been referred to podiatry. During an interview on 6/17/26 at 8:36 AM the Administrator stated if a resident had a referral to podiatry, they first ensure that the in-house podiatrist was coming to the facility within an acceptable amount of time from the referral because the in-house podiatrist comes to the facility quarterly. She stated if the in-house podiatrist had recently visited the facility, then they would accommodate the referral by getting the residents an appointment with an outside provider and arrange transport. She concluded that Resident #89 should have been seen by a podiatrist either when the in-house podiatrist came on 5/28/26 or he should have had an outside podiatrist appointment made.During an interview on 6/17/26 at 12:42 PM Physician #1 stated he remembered placing the order for a podiatry referral for Resident #89 in April of 2026. He stated Resident #89's toenails were thick and disformed and felt the resident should be seen by a podiatrist who would have the tools to trim and care for the toenails. He concluded because podiatry came to the facility in May 2026, he felt Resident #89 should have been seen by podiatry prior to now.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Physician #1, Physician #2, Hospice Clinical Manger, the Hospice Nurse and staff interviews, the facility failed to have effective systems in place to ensure hospice orders were processed when a resident was admitted to hospice services for 1 of 1 resident reviewed for hospice services (Resident #16). The findings included:Resident #16 was readmitted to the facility on [DATE] with diagnoses including failure to thrive, congestive heart failure, dementia, chronic respiratory failure, and diabetes. She was admitted to hospice services on 2/7/26. On 2/18/26, Resident #16 was sent to the emergency department after a fall and returned to the facility the same day.The Hospice Physician Order form dated 2/7/26 by the Hospice Nurse and the Hospice Physician revealed that Resident #16 was admitted to hospice for hypertensive heart disease with heart failure and to begin receiving the following medications as of 2/7/26:Acetaminophen, 650 milligrams (mg) rectal suppository every 6 hours as needed for pain/feverHaloperidol intramuscular solution 150 mg monthly for dementiaHyoscyamine sulfate 0.125 mg oral tablet as needed every 4 hours for excess secretionsLorazepam 1 mg tablet by mouth as needed every 4 hours for anxiety/agitationMorphine sulfate (concentrate) 20 mg/milliliter (mL) oral solution 0.25 mL every 4 hours as needed for pain/shortness of breathPromethazine HCl 12.5 mg tablet every 6 hours as needed for nausea/vomitingSenna Plus 8.6-50 mg tablet 2 tablets daily as needed for constipationReview of a nursing progress note dated 2/7/26 at 8:50 PM by Nurse #8 revealed that she had received a telephone call from the Hospice Nurse regarding Resident #16 being admitted to hospice. Physician #2 was made aware via telephone and needed to review the orders prior to being entered. The Hospice Nurse would notify the facility in the morning after Physician #2's review of the admission medications.On 6/18/26 at 10:38 AM Nurse #8 was interviewed via telephone. She revealed that the Hospice Nurse gave her the medication orders for Resident #16 over the phone on 2/7/26. However, she stated that hospice needed to wait to communicate with Physician #2 to notify him that Resident #16 was admitted to hospice. Nurse #8 indicated she contacted Physician #2 via telephone on 2/7/26 and was supposed to wait until Physician #2 reviewed the orders before making any medication changes.Review of Resident #16's medical record revealed no documentation that Physician #2 reviewed, signed, and dated the hospice orders for the added medications on 2/7/26. On 6/16/26 at 3:22 PM the Clinical Manager for Hospice was interviewed via telephone. She revealed that the Hospice Nurse gave all hospice paperwork to Nurse #5 on 2/7/26. The hospice paperwork included which medications needed to be added.On 06/17/26 at 2:46 PM Nurse #5 was interviewed via telephone. She revealed that when a resident was admitted to hospice, she would receive the orders from hospice in the facility and enter the orders into the medical record. Physician #2 would have to approve the orders and must be notified by the hospice nurses prior to Nurse #5 entering the orders upon admission to hospice. Nurse #5 indicated she did not recall when the hospice nurse was in the facility on 2/7/26 or whether or not she received the medication orders for Resident #16 directly from the hospice nurse.Review of the medical record revealed no evidence that Resident #16's medication orders dated 2/7/26 were processed by Nurse #5.A physician progress note dated 2/9/26 by Physician #2 revealed that the purpose of the note was for readmission from the hospital on 2/3/26. He documented that related to her hospice status he planned to discontinue all nonessential medications including atorvastatin, aspirin, Namenda, calcium carbonate, ferrous sulfate, and Atarax. No documentation was included regarding the new medications added on 2/7/26 by hospice.A nursing progress note dated 2/18/26 by Nurse #4 revealed that while hospice was in the building, she was instructed to enter new orders for Resident #16 including acetaminophen rectal suppository, morphine sulfate, hyoscyamine, promethazine, and lorazepam.Nurse #4 was interviewed on 6/16/26 at 3:55 PM. She revealed that hospice was in the facility on 2/18/26 at shift change, and they provided paperwork (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to add medication orders for Resident #16. Review of Resident #16's February 2026 Medication Administration Record (MAR) revealed the following orders were entered on 2/18/26 for medications previously ordered on 2/7/26:Acetaminophen, 650 milligrams (mg) rectal suppository every 6 hours as needed for pain/feverHaloperidol decanoate 100mg/milliliter (mL) intramuscular solution 150mg monthly for dementiaHyoscyamine sulfate 0.125mg oral tablet as needed every 4 hours for excess secretionsLorazepam 1mg tablet by mouth as needed every 4 hours for anxiety/agitationMorphine sulfate (concentrate) 20mg/mL oral solution 0.25mL every 4 hours as needed for pain/shortness of breathPromethazine HCl 12.5mg tablet every 6 hours as needed for nausea/vomitingSenna Plus 8.6-50mg tablet 2 tablets daily as needed for constipationOn 6/18/26 at 9:25 AM a telephone interview was conducted with Physician #1, who was the facility Medical Director. He revealed that hospice would oversee handling the symptom management and medications for hospice residents. Physician #1 stated that Physician #2 should have signed and dated the hospice medication orders when they were received. An interview with Physician #2 was conducted on 6/17/26 at 11:30 AM. He revealed that hospice orders were not orders but rather only recommendations. He as primary care physician had the ultimate authority of care management, including medication changes. Physician #2 stated that he could take as long as he wanted to accept or reject the hospice recommendations. Physician #2 indicated that from 2/7/26 through 2/18/26 he was evaluating the recommendations made by hospice, and there was no documentation of this activity. Physician #2 stated at some point he was consulted about Resident #16's hospice medication changes, but he could not recall the exact date.The Hospice Physician was interviewed via telephone on 6/17/26 at 9:16 AM. He revealed that when Resident #16 was admitted to hospice on 2/7/26, the medication orders should have been entered within 24 hours. On 6/18/26 at 10:47 AM the Director of Nursing (DON) was interviewed. She revealed that the Hospice Physician medication orders for Resident #16 should have been implemented when they were given to the facility on 2/7/26. The DON indicated Physician #2 should have documented when he reviewed the hospice orders. On 6/18/26 at 10:55 AM the Administrator was interviewed. She revealed that the hospice medication orders should have been reviewed and signed by Physician #2 in a timely manner.