STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365250	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckeye Care and Rehabilitation	1900 East Main Street Lancaster, OH 43130

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure residents were treated with dignity and respect. This affected three residents (#12, #30 and #31) observed for incontinence care and one resident (#45) of one resident self-propelling in the hallway. The facility census was 87. Findings include: 1. Medical record review revealed Resident #31 was admitted on [DATE] with diagnoses including multiple sclerosis, Parkinson's disease, altered mental status and urge incontinence. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #31 was cognitively intact for daily decision-making and was frequently incontinent of urine. Medical record review revealed Resident #30 was admitted on [DATE] with diagnoses including dementia, urinary tract infections, cognitive communication disorder, contractures and bipolar disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #30 was cognitively intact for daily decision-making, always incontinent of bowel and bladder. On 05/01/25 at 6:00 A.M., observation from the hallway revealed Resident #30 was positioned on her left side and Certified Nurse Assistant (CNA) #237 was observed providing incontinence care to the resident. Resident #30's buttocks and legs were exposed as the door to the room was open and the privacy curtain was not pulled shut. Observation of the floor revealed an incontinence product containing brown stool was observed on the floor without a barrier. Resident #31 was observed sitting on the toilet naked with her head lowered to her chest. Interview with CNA #237 and CNA #238 verified the above observations and the dignity of the residents were not maintained while providing morning care. 3. Medical record review revealed Resident #45 was admitted on [DATE] with diagnoses including heart failure, mild cognitive impairment, dementia, cognitive communication deficit and anxiety disorder. Review of the annual MDS assessment dated [DATE] revealed Resident #45 was cognitively intact for daily decision-making and required supervision or touching assistance with shower/bathe self. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/01/25 at 7:15 A.M., observation revealed Resident #45 was self-propelling in a wheelchair by the nurses' station wearing a pair of slippers and one, white bath towel was observed to be draped across her torso and groin. The resident's hair was wet and her shoulders and upper thighs to her feet were exposed. CNA #223 was following behind the resident from the shower room and was carrying the resident's bath supplies. At the time of the above observation, Activities #224 was passing out activity calendars and verified the above. Activities #224 stated the resident needed to be covered and went towards the resident to assist. While Resident #45 was still in the hallway, Resident #50 was coming out of his room to go to the dining room and looked down the hallway towards Resident #45. On 05/01/25 at 7:19 A.M., interview with CNA #223 stated she had assisted Resident #45 with her shower that morning and verified the resident was not completely covered when she left the shower room to go back to her room. CNA #223 verified the resident's dignity was not maintained. 4. Medical record review revealed Resident #12 was admitted on [DATE] with diagnoses including pneumonia, adult failure to thrive, dysphagia, cardiomyopathy, protein-calorie malnutrition and anxiety disorder. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #12 was cognitively intact for daily decision-making and was frequently incontinent of bowel and bladder. On 05/01/25 between 10:07 A.M. and 10:07 A.M., observation revealed CNA #226 gathered supplies to complete incontinence care for Resident #12 whose bed was next to a large window with the blinds open. An adjacent business parking lot and sidewalk were observed outside the resident's window. CNA #226 raised the resident's bed and rolled the resident onto her left side, removed her incontinence product revealing a large amount of loose brown stool and began incontinence care. At no time did CNA #226 close the blinds to maintain Resident #12's dignity during incontinence care. Interview on 05/01/25 at 10:24 A.M. with CAN #226 verified the blinds were left open during incontinence care for Resident #12. Review of the policy: Dignity revised February 2021 revealed residents were to be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. This included staff were to promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and treatments. This deficiency represents noncompliance investigated under Complaint Number OH00165005.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, self-reported incident (SRI) review, medical record review, policy review and interview, the facility failed to safeguard controlled substances to prevent misappropriation. This affected one resident (Resident #13) of three residents identified in a self-reported incident. The facility census was 87. Findings include: Medical record review revealed Resident #13 was admitted on [DATE] with diagnoses including diabetes mellitus, fracture of left tibia and fibula, benign prostatic hyperplasia, heart failure and urinary tract infection. Review of the SRI tracking number 258836 dated 03/30/25 revealed when the facility tried to reorder Resident #13's oxycodone (opioid), the pharmacy indicated that the medication could not be refilled as it was too soon. The pharmacy reported that 60 tablets of oxycodone 5 milligrams (mg) had been delivered to the facility on [DATE]. A review of the delivery receipt and the Controlled Drug Administration Record (CDR) confirmed that the medication had been received and registered in the facility's narcotic count. A comprehensive facility-wide search was conducted, including all medication carts and medication storage areas. Despite these efforts, facility staff were unable to locate the missing card of oxycodone, or the control sheet associated with Resident #13's oxycodone. The attending physician was immediately informed of the incident and the assessment findings. Licensed nurses have been reminded of the requirement to perform thorough shift change narcotic counts and report discrepancies immediately. A licensed pharmacist was reviewing CDR records and evaluating facility narcotic count protocols to identify potential areas for improvement in preventing future medication diversions. The Director of Nursing (DON) and designee were reviewing all current residents with oxycodone prescriptions, cross-referencing control sheets, pharmacy packing slips, and medication administration records to determine the root cause of the issue. The facility unsubstantiated misappropriation but indicated it was suspected. On 05/01/25 at 10:41 A.M., interview with Assisted Director of Nursing (ADON) #198 verified she was not aware there were unidentified controlled drugs being stored in the medication controlled lock box as discovered on 05/01/25. ADON #198 stated this was not an acceptable or approved practice at the facility. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/25 at 10:43 A.M., interview with ADON #198 verified misappropriation of Resident #13's controlled substance was identified when a missing bubble-pack card of 60 tablets of oxycodone 5 mg for Resident #13 when the pharmacy denied a request to refill the medication due to being refilled 10 days prior. ADON #198 stated she was very involved in this investigation especially reviewing the CDR and controlled substances. ADON #198 stated to her knowledge the facility has not been able to determine who or when the medications were misappropriated and/or removed from the facility. ADON #198 acknowledged there have been continued concerns identified through audits, as well as observations made during the current survey of documentation concerns related to signing out controlled substances and reconciliation sheets. 2. On 05/01/25 at 6:25 A.M., observation during reconciliation with Registered Nurse (RN) #235 and Licensed Practical Nurse (LPN) #236 revealed Resident #18 had a CDR for Norco 5/325 mg (opioid) indicating there should be six tablets of Norco 5/325 mg available for use. Observation of the Norco 5/325 mg bubble pack with Registered Nurse (RN) #235 and LPN #236 revealed there were five tablets in the bubble pack. At the time of the observation, RN #235 stated she administered Norco 5/325 mg tablet to Resident #18 at 5:00 A.M. and had forgotten to sign out the medication. RN #235 and LPN #236 verified the above at the time of the observation. 3. On 05/01/25 at 6:30 A.M., observation during reconciliation with RN #235 and LPN #236 revealed Resident #102 had an order to administer oxycodone 5/325 mg every six hours as needed for pain. Review of the CDR at the time of the observation revealed there were seven tablets available for use. Observation of the oxycodone 5/325 mg bubble-pack revealed six tablets were available for use. At the time of the observation, RN #235 stated she administered the oxycodone to Resident #102 at 6:00 A.M. but forgot to sign it out. RN #235 and LPN #236 verified the above at the time of the observation. 4. On 05/01/25 at 6:40 A.M., reconciliation of controlled medications with RN #235 and LPN #236 for Main Street Hall revealed there were 25 bubble pack cards of controlled medications, and the Controlled Medication Shift Change Log revealed there were 24 count sheets. Review of the Controlled Medication Shift Change Log dated 04/27/25 through 04/30/25 revealed the following: On 04/28/25, the Total Count Sheets were 24. On 04/29/25 at 11:00 P.M., five sheets were added, and six sheets were removed leaving a Total Count Sheet of 23. On 04/30/25 at 7:00 A.M., three sheets were added leaving a Total Count Sheet of 26. On 04/30/25 at 1:37 P.M., one card was removed (discharged home) leaving 25 (signed by on-coming nurse). On 04/30/25 at 10:00 P.M., two cards were removed, and Total Count Sheets was 24. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/25 at 6:40 A.M., interview with RN #235 and LPN #236 verified the total count sheets did not match the number of controlled bubble packs. The Total Count Sheets should have been 23 instead of 24 on 04/30/25 at 10:00 P.M. At the time of the observation, the Total Count Sheets was 23 and there were 25 medication cards. RN #235 and LPN #236 verified the above was not discovered during reconciliation at the start of their shift on 04/30/25 at 10:00 P.M. when reconciliation was done. Review of the policy: Abuse Prevention dated 10/02/19 revealed the facility will prohibit abuse, mistreatment, neglect, misappropriation of resident property and exploitation for all residents. The deficient practice was corrected on 04/09/25 when the facility implemented the following corrective actions: On 03/30/25, the DON/designee completed a count of all controlled substances, and no additional issues were identified. On 03/30/35, the DON/designee contacted the county police department and filed a report with associated case #25-16450. On 03/30/25, the DON/designee initiated re-education to all current licensed nurses regarding the receipt process and accurate counts during shift changes of controlled medications. On 03/30/25, the pharmacy was notified of the incident and was to send a licensed pharmacist by 04/08/25 to evaluate the current controlled medication validation process and staff education. On 03/31/25, the DON/designee notified the Ohio Department of Health of the incident. On 03/31/25, the DON/designee initiated daily audits for five days, then weekly for four weeks and PRN (as needed) thereafter. On 04/03/25, the DON/designee initiated re-education with nursing clinical managers of the importance of consistent and organized oversight of the controlled documentation administration records. On 04/04/25, the DON/designee notified the pharmacy that any bills were to be directed to the facility to ensure the residents were reimbursed for the potentially misappropriated medications. On 04/04/25, RN #400 remained under suspension. On 04/04/25, the county sheriff was notified of the investigation findings. A full review of licensed nursing staff credentials were completed and confirmed all licenses remained in good standing. On 04/07/25, the pharmacy initiated new measures to monitor controlled medications more closely including all controlled medication invoices were to be signed by two nurses, completed controlled medication cards and count sheet were to be placed in a binder and double checked by the unit manager and held until the pharmacist's next visit for his review on 04/22/25. On 04/09/25, RN #400 employment was terminated. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/25, pharmacy returned to review previous measures implemented and no concerns were identified. This deficiency represents past noncompliance investigated under Complaint Number OH00165005.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to timely assess an indwelling catheter, treat urinary tract infections and provide adequate incontinence care. This affected one resident (#13) of three residents reviewed for urinary tract infections and one resident (#12) of one resident observed for incontinence care. The facility census was 87. Findings include: 1. Medical record review revealed Resident #13 was admitted on [DATE] with diagnoses including left fibula and tibia fracture, heart failure, chronic kidney disease, benign prostatic hyperplasia (BPH) without lower urinary tract symptoms, and urinary tract infection (UTI). Review of the Foley Catheter Evaluation dated 02/28/25 revealed Resident #13's indwelling catheter was being utilized for better pain control and mobility. The evaluation was to be completed upon admission, weekly for four weeks and then quarterly thereafter. The goal was to minimize the invasive methods used for resident safety, health, and overall wellbeing. Further review of the medical record revealed no evidence of a comprehensive evaluation of Resident #13's indwelling catheter between 02/28/25 and 04/30/25. Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed the resident had an indwelling catheter and no UTI in the last 30 days. Review of the quarterly MDS assessment dated [DATE] revealed Resident #13 was cognitively intact for daily decision-making, did not utilize an indwelling catheter, was frequently incontinent of urine and had a UTI in the last 30 days. Review of the electronic Physician Orders dated 02/27/25 to 04/11/25 revealed the resident utilized an indwelling urinary catheter. An order for a trial removal of the indwelling catheter was completed on 04/11/25, and the resident's indwelling catheter was discontinued. Review of the Progress Notes dated 04/11/25 revealed Resident #13 requested his indwelling catheter to be removed and to evaluate if he really needed it. Physician Assistant #304 evaluated the resident, and an order was received to remove the indwelling catheter, obtain a urinalysis and start an antibiotic pending urine result. The resident voided cloudy urine, and the urine sample was obtained; however, there was no evidence the urine sample was sent to the laboratory. Review of the Physician Assistant #304's Progress Note dated 04/14/25 revealed Resident #13 was reassessed and complained of back pain and dysuria (difficulty urinating) over the weekend. The resident's urine was noted to be cloudy, and he stated he felt a little better this morning. Continue antibiotic pending urinalysis results and encourage fluids. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Culture, Urine report dated 04/18/25 revealed Resident #13's urine specimen was collected on 04/14/25 and final results were reported on 04/18/25. The urine culture was positive for Escherichia coli (e-coli) greater than 100,000 CFU/mL (colony-forming-units per milliliter), and enterococcus faecalis 26-30, 000 CFU/mL. The urinalysis included 2+ blood, 4+ leukocytes, six to 20/HPF (high power field) red blood cells, and greater than 50 HPF white blood cells. Review of the Antibiotic Sensitivity revealed e-coli was sensitive to Bactrim (antibiotic) but not enterococcus faecalis. Review of the electronic Medication Administration Record (eMAR) dated April 2025 revealed Resident #13 was administered Bactrim DS 800-160 milligrams mg between 04/11/25 and 04/18/25 for infection and Cipro 500 mg (antibiotic) between 04/21/25 and 04/28/25 for UTI. Review of the resolved care plan: Indwelling Foley Catheter: Skin breakdown/discomfort/diagnosis BPH/pain management initiated 02/27/25 and discontinued 04/15/25 revealed interventions included to monitor/record/report signs and symptoms of UTI to physician. On 05/04/25 at 3:02 P.M., interview with Licensed Practical Nurse (LPN) #227 verified Resident #13's indwelling catheter was only assessed upon admission and had been utilized due to the difficulty using a urinal due to his leg brace. LPN #27 verified the resident had not been seen by a urologist, was symptomatic of a possible UTI prior to the catheter being discontinued, the urinalysis was obtained not sent timely to the lab and the resident had taken two different antibiotics to treat the diagnosed UTI due to the first antibiotic was not sensitive to one of the two organisms. LPN #227 stated she has spoken to PA #304 regarding ordering antibiotics prior to urinalysis/culture but he continues to write it in his progress note and order the antibiotics to start treatment without urine test results. On 05/05/25 at 3:50 P.M., an electronic interview with the Administrator verified the urinalysis/culture was ordered on 04/11/25; however, the lab will not do STAT (immediate) urinalysis, the lab didn't pick up the sample on 04/11/25 and the earliest they would come was on 04/14/25. The Administrator stated the facility had limited options, as far as, labs in their geographical location. 2. Medical record review revealed Resident #12 was admitted on [DATE] with diagnoses including pneumonia, adult failure to thrive, dysphagia, cardiomyopathy, protein-calorie malnutrition and anxiety disorder. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #12 was cognitively intact for daily decision-making and was frequently incontinent of bowel/bladder. On 05/01/25 between 10:07 A.M. and 10:35 A.M., observation revealed CNA #226 gathered supplies to complete incontinence care for Resident #12 whose bed was next to a large window with the blinds open. An adjacent business parking lot and sidewalk were observed outside the resident's window. CNA #226 raised the resident's bed and rolled the resident onto her left side, removed her incontinence product revealing a large amount of loose brown stool and began incontinence care. CNA #226 was observed using multiple disposable incontinence wipes in a circular motion on the resident's buttocks, legs and groin in attempts to clean the excessive amount of soft, loose stool. CNA #226 placed a clean incontinence product under the resident while brown stool was still observed on her buttocks and rectum. CNA #226 turned the resident onto her back and stool was observed on the resident's groin and clean incontinence product under the resident. CNA #226 continued to use the disposable incontinence wipes and then fastened the incontinence product to the resident. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/25 at 10:24 A.M., an interview with CNA #226 verified there was stool on both the resident's groin/peri-area and the clean incontinence product that was placed on the resident during incontinence care. CNA #226 stated Resident #12 consistently had loose stool and staff would have to check her every 20-minutes, and they would clean her again at that time. On 05/01/25 at 10:35 A.M., interview with Assistant Director of Nursing (ADON) #198 verified CNA #226 had not provided appropriate incontinence care and should not have left the resident soiled. Review of the policy: Urinary Continence and Incontinence - Assessment and Management revised August 2022 revealed indwelling urinary catheters were to be used sparingly for appropriate indications only. Identification and management of UTI will follow relevant clinical guidelines and antibiotics will be used appropriately. If a resident was admitted from the hospital with a newly placed indwelling catheter, the attending physician and staff were to evaluate the potential for removing it, depending on the current condition and rationale for its original placement. Where indicated, the staff and physician will treat symptoms of a UTI. The physician will identify situations in which an indwelling urethral catheter was indicated and document why other alternative were not feasible. If used, the physician and staff will document the clinical indications for use of the catheter and utilize a standardized tool to document its ongoing need. If an indwelling catheter is needed, staff will monitor for and report complications such as evidence of a symptomatic infection. This deficiency represents noncompliance investigated under Complaint Number OH00165005. This deficiency substantiates Complaint Number OH00165005.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to provide adequate care and services for a gastrostomy tube during medication administration. This affected one resident (#51) of three residents with an enteral tube observed for medication administration. The facility census was 87. Findings include: Medical record review revealed Resident #51 was admitted on [DATE] with diagnoses including dysphagia, nontraumatic intracranial hemorrhage, congestive heart failure, gastrostomy and dementia. Review of Resident #51's Order Summary Report dated May 2025 revealed the resident was ordered a regular diet, pureed texture and thin liquids. The resident was to receive 200 milliliters (mL) bolus of water twice a day. On 05/01/25 between 8:15 A.M. and 8:23 A.M., observation of Resident #51's medication administration revealed Licensed Practical Nurse (LPN) #230 prepared the following medications: Xanax 0.5 milligrams (mg) (antianxiety), Percocet 5/325 mg (opioid), allopurinol 100 mg half-tablet (reduces uric acid), Coreg 25 mg (beta-blocker to lower heart rate and treat heart failure), Eliquis 5 mg (anticoagulant), Lasix 20 mg (diuretic), multivitamin (supplement), Claritin 10 mg (antihistamine), losartan 25 mg (treats high blood pressure), Namenda 5 mg (treats moderate to severe Alzheimer's), Protonix 20 mg (decreases stomach acid) and Zoloft mg (antidepressant). LPN #230 put the medications into a medication pouch, crushed the above medications, emptied the medications into a medication cup, mixed in 60 mL of water and administered the medications into the gastrostomy tube (g-tube). The g-tube was not checked for placement or flushed prior to administration. After administering the medications into the g-tube, LPN #230 placed the piston into a plastic bag, walked into the bathroom, obtained 60 mL of water into the syringe and flushed the g-tube. LPN #230 then replaced the end cap on the g-tube, removed her gloves and left the room. On 05/01/25 at 8:23 A.M., an interview with LPN #230 verified she did not check the g-tube for placement, flush the g-tube prior to administration of the medications, and did not provide the ordered 200 mL of fluid as ordered because she forgot the cup and did not want to set the cup down. Review of the policy: Administering Medications through an Enteral Tube revised November 2018 included administering each medication separately, flush between medications and use warm, purified water for diluting medications and for flushing. Placement of the enteral tube was to be verified, and medications administered, and if administering more than one medication, flush with prescribed amount between medications and when the last of the medication begins to drain from the tubing, flush the tubing with prescribed amount. This deficiency was an incidental finding identified during the complaint investigation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 28704 Based on observation, medical record review, controlled drug sheet review, policy review and interview, the facility failed to ensure a comprehensive program to safeguard controlled substances and ensure medications were administered as ordered. This affected four residents (#18, #21, #38 and #102) sampled during reconciliation of controlled substances and one resident (#36) of three residents reviewed for infection. The census was 87. Findings include: 1. On 05/01/25 between 6:15 A.M. and 6:45 A.M., observation of reconciliation of controlled drugs for the Maple Avenue Hall and Main Street Hall revealed the following: a. Reconciliation of controlled medications with Registered Nurse (RN) #235 and Licensed Practical Nurse (LPN) #236 for Maple Avenue Hall revealed RN #235 opened the medication cart and unlocked the narcotic drawer. The locked narcotic drawer contained bubble packs of medications, transdermal patches, a community-filled prescription bottle and a disposable water cup that contained two pill-crusher pouches (pouch to put medications into prior to the crushing process to help eliminate cross contamination) stapled shut with an unknown amount of round, blue-scored tablets. The pouches were full and at the time of the observation, RN #235 stated she was unable to complete an accurate count of how many tablets were in the pouches without removing the staple, and there was no name of the drug or resident name on the pill-crusher pouches. RN #235 stated she had notified the Director of Nursing (DON) of her concerns when reconciling at the beginning of her shift and earlier this morning when she arrived. The disposable plastic drinking cup was observed to have Resident #21's name and oxycodone 5 milligrams (mg) written in black marker on the cup. The pouches of the blue-scored tablets did not include a pharmacy label or proper identification only handwritten initials and the number '30'. There was no pharmacy label or identifying information of what medication was in the sleeves, drug name, strength, ordering physician or expiration date. On 05/01/25 between 6:52 A.M. and 7:00 A.M., observation and interview with the DON verified the locked narcotic drawer contained two pill-crusher pouches, the pouches were not labeled with required information, and she did not know how long they had been in there. The DON stated she had just become aware of the situation prior to the surveyor's arrival at the facility this morning. The DON stated the resident had the prescription filled in the community prior to her admission and brought them to the facility in the original prescription bottle. The DON stated she believed the unlabeled pills were Resident #21's oxycodone (opioid) as the prescription bottle (also located in the locked narcotic drawer of the medication cart) was for oxycodone and the pills looked the same. The DON stated she does not know why anyone would remove them from the original prescription bottle and separate them out like that, but that was what she believed had happened. The DON verified the two pouches of blue tablets could be something else since not labeled but felt they were the resident's oxycodone. Review of the Controlled Drug Receipt/Record/Disposition Form (CDR) with the DON revealed there should be 65 tablets of oxycodone available for use; however, there were only five tablets in the prescription bottle. The DON stated there were probably '30' tablets in each pouch as there was the number '30' written on each pouch but the pouches were not labeled, and the disposable cup did not meet the criteria of proper labeling. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckeye Care and Rehabilitation	1900 East Main Street Lancaster, OH 43130

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 05/01/25 at 6:25 A.M., observation during reconciliation with RN #235 and LPN #236 revealed Resident #18 had a CDR for Norco 5/325 mg (opioid) indicating there should be six tablets of Norco 5/325 mg available for use. Observation of the Norco 5/325 mg bubble pack with RN #235 and LPN #236 revealed there were five tablets in the bubble pack. At the time of the observation, RN #235 stated she administered Norco 5/325 mg tablet to Resident #18 at 5:00 A.M. and had forgotten to sign out the medication. RN #235 and LPN #236 verified the above at the time of the observation. c. On 05/01/25 at 6:30 A.M., observation during reconciliation with RN #235 and LPN #236 revealed Resident #102 had an order to administer oxycodone 5/325 mg every six hours as needed for pain. Review of the CDR at the time of the observation revealed there were seven tablets available for use. Observation of the oxycodone 5/325 mg bubble-pack revealed six tablets were available for use. At the time of the observation, RN #235 stated she administered the oxycodone to Resident #102 at 6:00 A.M. but forgot to sign it out. RN #235 and LPN #236 verified the above at the time of the observation. d. Reconciliation of controlled medications with RN #235 and LPN #236 for Main Street Hall revealed there were 25 bubble pack cards of controlled medications, and the Controlled Medication Shift Change Log revealed there were 24 count sheets. Review of the Controlled Medication Shift Change Log dated 04/27/25 through 04/30/25 revealed the following: On 04/28/25, the Total Count Sheets were 24. On 04/29/25 at 11:00 P.M., five sheets were added, and six sheets were removed leaving a Total Count Sheet of 23. On 04/30/25 at 7:00 A.M., three sheets were added leaving a Total Count Sheet of 26. On 04/30/25 at 1:37 P.M., one card was removed (discharged home) leaving 25 (signed by on-coming nurse). On 04/30/25 at 10:00 P.M., two cards were removed, and Total Count Sheets was 24. On 05/01/25 at 6:40 A.M., interview with RN #235 and LPN #236 verified the total count sheets did not match the number of controlled bubble packs. The Total Count Sheets should have been 23 instead of 24 on 04/30/25 at 10:00 P.M. At the time of the observation, the Total Count Sheets was 23 and there were 25 medication cards. RN #235 and LPN #236 verified the above was not discovered during reconciliation at the start of their shift on 04/30/25 at 10:00 P.M. when reconciliation was done. 2. Medical record review revealed Resident #21 was admitted on admitted on [DATE] with diagnoses including osteoporosis, spinal stenosis, chronic pain, osteoarthritis and joint pain. Review of the electronic Physician Orders dated 05/01/25 revealed Resident #21 was ordered oxycodone 5 mg every eight hours PRN (as needed) for pain rated on a scale of one to 10. Review of the electronic Medication Administration Record (eMAR) dated April 2025 revealed Resident #21 was administered oxycodone 5 mg PRN as follows: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/25 at 5:37 A.M. On 04/26/25 at 9:37 A.M. and 6:10 P.M. On 04/27/25 at 5:01 A.M., 1:00 P.M. and 9:05 P.M. On 04/28/25 at 5:05 A.M. On 04/29/25 at 5:20 A.M. On 04/30/25 at 1:12 A.M. Review of Resident #21's oxycodone 5 mg CDR dated 04/25/25 revealed a supply of 79 tablets were received. On 05/01/25 at 6:17 A.M., Resident #21's CDR for oxycodone 5 mg indicated 65 tablets were available for use and had received oxycodone per the CDR as follows: On 04/25/25 at 5:37 A.M. and 3:20 P.M. On 04/26/25 at 9:37 A.M. and 6:10 P.M. On 04/27/25 at 5:00 A.M., 1:00 P.M. and 9:05 P.M. On 04/28/25 at 5:05 A.M. and 6:40 P.M. On 04/29/25 at 5:20 A.M. and 2:30 P.M. On 04/30/25 at 1:13 A.M., 9:10 A.M. and 6:10 P.M. On 05/01/25 at 11:00 A.M., interview with Assistant Director of Nursing (ADON) #198 verified Resident #21's eMAR indicated nine doses were administered between 04/25/25 and 05/01/25, and the CDR indicated 14 doses were administered within the same timeframe. ADON #198 stated the nurses do forget to document on the eMAR which makes it look like more doses of oxycodone were dispensed and not administered to the resident (five doses) but felt it was more of a documentation error than someone taking them. 3. Medical record review revealed Resident #38 was admitted on [DATE] with diagnoses including nontraumatic intracerebral hemorrhage, dementia, contracture of other specified joint and hemiplegia. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #38 was severely impaired for daily decision-making, did not complain of pain and received scheduled pain medications. Review of the Order Summary Sheet dated April 2025 revealed Resident #38 was ordered to receive oxycodone 5 mg three times a day for pain. Review of the CDR dated 04/08/25 revealed Resident #38 received oxycodone 5 mg once on 04/19/25 at 9:45 A.M., once on 04/20/25 at 9:45 A.M., twice on 04/24/25 at 9:30 A.M. and 5:45 P.M., and once on 04/25/25 at 9:30 A.M (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the eMAR dated April 2025 revealed Resident #38 was administered oxycodone 5 mg three times a day as ordered including 04/19/25, 04/20/25, 04/24/25 and 04/25/25. Review of the care plan: At Risk for Pain due to problems including but not limited to contractured joints, chronic pain, craniectomy and hydrocephalus with shunt revised 07/09/24 revealed interventions including to administer pain medications as ordered and monitor for effectiveness. On 05/01/25 at 2:00 P.M., interview with ADON #198 verified after review of the CDR for Resident #38 that there was a discrepancy in the eMAR and CDR for Resident #38. ADON #198 stated the Controlled Medication Shift Change Log did not reflect the discrepancies. ADON #198 stated RN #197 did not administer the scheduled pain medications because she did think the resident needed it. ADON #198 denied any side effects or concerns with the current dose ordered and administered routinely to the resident stating it was the nurse's belief system that kept her from administering the medications to the resident. ADON #198 stated the nurse had been re-educated at least twice regarding the administration of medications per physician orders, and she would have to educate her again. 4. Medical record review revealed Resident #36 was admitted on [DATE] with diagnoses including respiratory failure, atrial fibrillation, heart failure and anxiety. Review of the quarterly MDS assessment dated [DATE] revealed Resident #36 was moderately impaired for daily decision-making and had been receiving antibiotics. Review of the electronic Physician Orders dated February 2025 revealed Resident #36 was ordered to receive Augmentin 875-125 mg (antibiotic) every 12 hours for six days for pneumonia. Review of the eMAR dated February 2025 revealed Augmentin 875-125 mg was administered between 02/19/25 and 02/25/25 for 11 of 12 ordered doses. There was no evidence Resident #36 had received the 12th dose of Augmentin. On 04/30/25 at 2:17 P.M., interview with LPN #227 verified Resident #36 was not administered Augmentin as ordered as indicated above. Review of the policy: Administering Medications revised April 2019 revealed medications were to be administered in a safe and timely manner, and as prescribed. The procedure included the individual administering the medication was to check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. If a dosage was believed to be inappropriate, excessive or identified as having potential adverse consequences for the resident, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy: Controlled Substances revised November 2022 revealed the facility complied with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of controlled medications. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: records of personnel access and usage, MAR, declining inventory records and destruction, waste and return to pharmacy records. Nursing staff was to count controlled medication inventory at the end of each shift using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the DON. The consultant pharmacist or designee routinely monitors controlled storage records. This deficiency represents noncompliance investigated under Complaint Number OH00165005.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to provide adequate care and services for a gastrostomy tube. This affected one resident (#51) of three residents observed for medication administration with 12 errors out of 25 opportunities resulting in an error rate of 48%. The census was 87. Findings include: Medical record review revealed Resident #51 was admitted on [DATE] with diagnoses including dysphagia, nontraumatic intracranial hemorrhage, congestive heart failure, gastrostomy and dementia. Review of Resident #51's Order Summary Report dated May 2025 revealed medications could be crushed and given with food if appropriate. Further review revealed no order to administer medications via Resident #51's enteral tube. On 05/01/25 between 8:15 A.M. and 8:23 A.M., observation of Resident #51's medication administration revealed Licensed Practical Nurse (LPN) #230 prepared the following medications: Xanax 0.5 milligrams (mg) (antianxiety), Percocet 5/325 mg (opioid), allopurinol 100 mg half-tablet (reduces uric acid), Coreg 25 mg (beta-blocker to lower heart rate and treat heart failure), Eliquis 5 mg (anticoagulant), Lasix 20 mg (diuretic), multivitamin (supplement), Claritin 10 mg (antihistamine), losartan 25 mg (treats high blood pressure), Namenda 5 mg (treats moderate to severe Alzheimer's), Protonix 20 mg (decreases stomach acid) and Zoloft mg (antidepressant). LPN #230 put the medications into a medication pouch, crushed the above medications, emptied the medications into a medication cup, mixed in 60 mL of water and administered the medications into the gastrostomy tube (g-tube). The g-tube was not checked for placement or flushed prior to administration. After administering the medications into the g-tube, LPN #230 placed the piston into a plastic bag, walked into the bathroom, obtained 60 mL of water into the syringe and flushed the g-tube. LPN #230 then replaced the end cap on the g-tube, removed her gloves and left the room and stated the medication administration was complete. On 05/01/25 at 8:38 A.M., an interview with LPN #230 verified the above medications were administered via g-tube including Protonix that she crushed. LPN #230 stated 'if it cannot be crushed, how am I supposed to give it?' and verified the order indicated the medications were to be administered orally. At the time of the observation, there was no current order to administer medications via g-tube. Review of the policy: Administering Medications through an Enteral Tube revised November 2018 revealed the purpose of this procedure was to provide guidelines for the safe administration of medications through an enteral tube. Preparation included to verify that there was a physician's medication order for this procedure. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy: Administering Medications revised April 2019 revealed medications were to be administered in a safe and timely manner, and as prescribed. The procedure included the individual administering the medication was to check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. This deficiency represents noncompliance investigated under Complaint Number OH00165005.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure medications were labeled as required. This affected one resident (#21) of four residents sampled during reconciliation of controlled substances. The census was 87. Findings include: Medical record review revealed Resident #21 was admitted on admitted on [DATE] with diagnoses including osteoporosis, spinal stenosis, chronic pain, osteoarthritis and joint pain. Review of the electronic Physician Orders dated 05/01/25 revealed Resident #21 was ordered oxycodone 5 milligrams (mg) every eight hours PRN (as needed) for pain rated a one to 10. Review of Resident #21's oxycodone 5 mg Controlled Drug Receipt/Record/Disposition Form (CDR) revealed there was a supply of 65 tablets available for use. On 05/01/25 between 6:15 A.M. and 6:45 A.M. observation of reconciliation of controlled drugs with Registered Nurse (RN) #235 and Licensed Practical Nurse (LPN) #236 for Maple Avenue Hall revealed RN #235 opened the medication cart and unlocked the narcotic drawer. The locked drawer contained a disposable water cup with two pill-crusher pouches (pouch to put medications into prior to the crushing process to help eliminate cross contamination) stapled shut with an unknown amount of round, blue-scored tablets. The pouches were full and at the time of the observation, RN #235 stated she was unable to complete an accurate count of how many tablets were in the pouches without removing the staple and regardless there was no name of the drug or resident on the pill-crusher pouches. RN #235 stated she had notified the Director of Nursing (DON) of her concerns. The disposable plastic drinking cup was observed to have Resident #21's name and oxycodone 5 mg written in black marker on the cup. The pouches of the blue-scored tablets did not include a pharmacy label or proper identification only handwritten initials and the number '30'. There was no pharmacy label or identifying information of what medication was in the sleeves drug name strength or ordering physician. On 05/01/25 between 6:52 A.M. and 7:00 A.M., an interview with the DON verified the medications were not properly labeled and stated she had just became aware of the situation that morning prior to the surveyor's arrival at the facility. The DON stated the resident had filled the prescription prior to admission and brought them with her in a prescription bottle. The DON stated she was not sure what medication was in the stapled pill crusher pouches but believed they were Resident #21's oxycodone as the prescription bottle located in the locked narcotic drawer of the medication cart was for oxycodone as the CDR indicated a total of 65 tablets were left and only five tablets were in prescription bottle. The DON stated there were probably '30' tablets in each pouch as there was the number '30' written on each pouch but verified there was no drug label of what the medication was. The DON stated it appeared the staff was counting the unlabeled, blue-scored tablets as 60 tablets of oxycodone for Resident #21, but there was no way to know what those tablets actually were or how many were in the pouches. The DON verified there were only five oxycodone tablets in the prescription bottle labeled oxycodone 5 mg for Resident #21. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy: Medication Labeling and Storage dated February 2023 revealed medications and biologicals were to be stored in the packaging, containers or other dispensing systems in which they were received. Only the issuing pharmacy is authorized to transfer medications between containers. The medication label includes, at a minimum: medication name (generic and/or brand); prescribed dose, strength, expiration date, when applicable; resident's name, route of administration and appropriate instructions and precautions. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. Only the dispensing pharmacy may label or alter the label on a medication container or package and medications may not be transferred between containers. This deficiency was an incidental finding identified during the complaint investigation.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, policy review and interview, the facility failed to monitor/log infections and possible trends and failed to perform handwashing when indicated. This affected one resident (#30) of three residents observed for incontinence care and one resident (#36) of three residents reviewed for urinary tract infections. The census was 87. Findings include: 1. Medical record review revealed Resident #36 was admitted on [DATE] with diagnoses including respiratory failure, atrial fibrillation, heart failure and anxiety. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #36 was moderately impaired for daily decision-making, was always incontinent of bladder/bowel and had been receiving antibiotics. Review of the hospital History and Physical revised 02/16/25 revealed Resident #36 had been diagnosed and treated for sepsis, urinary tract infection (UTI) and pneumonia. Review of the Infection Control Log dated February 2025 revealed no evidence Resident #36 had been diagnosed and treated for sepsis or a UTI on 02/16/25. On 04/30/25 between 3:54 P.M. and 4:23 P.M., interview with Licensed Practical Nurse (LPN) #227 stated she was the infection preventionist for the facility and verified Resident #36 was not identified on the ICC log as having been diagnosed with sepsis or UTI while in hospital. LPN #227 further stated there had been no trends or patterns identified to date even though there had been three of four residents diagnosed with UTI's with the organism e-coli. 2. Medical record review revealed Resident #30 was admitted on [DATE] with diagnoses including dementia, urinary tract infections, cognitive communication disorder, contractures and bipolar disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #30 was cognitively intact for daily decision-making, always incontinent of bowel and bladder. On 05/01/25 between 6:00 A.M. and 6:10 A.M., observation revealed Resident #30 was observed positioned on her left side and Certified Nurse Assistant (CNA) #237 was observed providing incontinence care to the resident. Observation of the floor revealed an incontinence product with brown stool was lying on the floor without a barrier. CNA #237 was observed wearing gloves while she cleaned stool from the resident's buttock using disposable incontinence wipes, the soiled wipes were discarded, and a new incontinent product was applied. CNA #237 straightened the bed linens, was observed removing her gloves and left the room. CNA #237 returned to the room with a pillowcase , applied new gloves, applied ChapStick to her gloved hand and wiped the ChapStick onto the resident's lips. At no time was CNA #237 observed washing her hands before or after the glove changes. On 05/01/25 at 6:10 A.M., interview with CNA #237 verified the above. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy: Handwashing/Hand Hygiene dated October 2023 revealed hand hygiene was indicated after contact with blood, body fluids or contaminated surfaces, after touching a resident or their environment and immediately after glove removal. The use of gloves does not replace hand washing/hand hygiene. Review of the policy: Surveillance for Infections revised September 2017 revealed the infection preventionist will conduct ongoing surveillance for healthcare associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions and to prevent future infections. When infection or colonization with epidemiologically important organisms are suspected, cultures may be sent for identification or confirmation. Cultures will be further screened for sensitivity to antimicrobial medication to help determine treatment measures. This deficiency represents non-compliance investigated under Complaint Number OH00165005.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, policy review and interview, the facility failed to implement appropriate antibiotic stewardship. This affected one resident (#13) of three residents sampled for infections. The facility census was 87. Findings include: Medical record review revealed Resident #13 was admitted on [DATE] with diagnoses including left fibula and tibia fracture, heart failure, chronic kidney disease, benign prostatic hyperplasia without lower urinary tract symptoms and urinary tract infection (UTI). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 was cognitively intact for daily decision-making, did not utilize an indwelling catheter, was frequently incontinent of urine and had a UTI in the last 30 days. Review of the Progress Note dated 04/14/25 revealed Resident #13 complained of back pain and dysuria (difficulty urinating) over the weekend, and his urine was noted to be cloudy. Urinalysis sent for analysis and prophylaxis antibiotic Bactrim pending results. Will continue antibiotic pending urinalysis results and encourage fluids. Review of the monthly electronic Physician Orders dated April 2025 revealed Resident #13 had an indwelling urinary catheter between 02/27/25 and 04/11/25. Review of the Culture, Urine report dated 04/18/25 revealed Resident #13's urine specimen was collected on 04/14/25 and final results were reported on 04/18/25. The urine culture was positive for Escherichia coli (e-coli) greater than 100,000 CFU/mL (colony-forming-units per milliliter), and enterococcus faecalis 26-30, 000 CFU/mL. Review of the Antibiotic Sensitivity revealed e-coli was sensitive to Bactrim but not enterococcus faecalis. Review of the Medication Administration Record (MAR) dated April 2025 revealed Resident #13 was administered Bactrim DS 800-160 milligrams (mg) between 04/11/25 and 04/18/25 for an infection pending urine culture results. Further review of the MAR revealed the resident was started on Cipro 500 mg (antibiotic) between 04/21/25 and 04/28/25 after the urine culture results were received on 04/18/25. On 05/01/25 at 4:40 P.M., an interview with Licensed Practical Nurse (LPN) #227 verified Resident #13 was started on antibiotics on 04/11/25 prior to receiving urinalysis or urine culture results. LPN #227 stated she has spoken with Physician Assistant #304 about antibiotic stewardship, but he continues to order antibiotics prophylactic pending any test/culture results without knowing if the antibiotic was appropriate or not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365250	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckeye Care and Rehabilitation	1900 East Main Street Lancaster, OH 43130

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy: Infections-Clinical Protocols revised March 2018 revealed when a resident is suspected to have an infection, assessment was to be completed, and physician notified. If infection was suspected a general work-up should focus on low-risk that have a reasonable diagnostic yield and likely to improve resident management. Based on review of the clinical situation, pertinent lab and diagnostic testing, the physician will determine if antibiotics were warranted or if started should continue or change. This deficiency was an incidental finding identified during the complaint investigation.